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**Discursive Power Games in Counselling Psychologists' Therapeutic Accounts of
Working with Male Sexual Dysfunction
A Foucauldian Analysis**

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Discursive Power Games in Counselling Psychologists'
Therapeutic Accounts of Working with Male
Sexual Dysfunction: A Foucauldian Analysis

by

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A thesis submitted in partial fulfilment of the requirements for the
degree of PsychD in Counselling Psychology

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Abstract

Male sexual dysfunction is considered to be a problematic discursive site due to the diverse ways in which it is constructed and therapeutically conceptualised. Under-researched within the discipline of counselling psychology to date, this diagnostic category needs to be explored to identify ways in which counselling psychologists construct this presenting problem. Therefore the aim of this research was to interrogate how a volunteer group of counselling psychologists understood and worked with male sexual dysfunction in order to make visible some of the masked discursive practices related to its diverse constructions. Ten counselling psychologists were interviewed and a Foucauldian discourse analysis conducted, which interrogated the discursive power games implicated in these participants' accounts. The findings produced firstly identified the wider contextual cultural norms that seemed to regulate male sexuality within gendered masculinity discourses. Secondly, three distinct discursive therapeutic subject positions and their related power games were identified as talked about by these participants. Overall, it is argued that these findings indicate that for these counselling psychologists, male sexual dysfunction is a mutable, diversely power-laden, and thereby problematic, construct. Furthermore this analysis may be understood as a contribution to counselling psychology in raising practitioners' awareness to the power games in their talk about working with male sexual dysfunction.

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Transcription notation conventions

[...] indicates where material is deliberately omitted.

(text) brackets surround words for speech clarification.

(*text*) brackets with italicized words indicate where, for example, there is laughter.

[text] indicates a clarification of relevant information.

(.) indicates a short pause.

(Malson, 1998. p.xv)

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Chapter One

Problematizing male sexual dysfunction in counselling psychology

"...sex was not only a matter of sensation and pleasure, law and taboo but also of truth and falsehood, that the truth of sex became something fundamental, useful, or dangerous, precious or formidable; in short, that sex was constituted as a problem of truth"

McWhorter 1999, p.25

1.1 Introduction to Chapter One

This research is about the power of language, specifically the talk of counselling psychologists (CoPs) in their therapeutic accounts of working with male sexual dysfunction (MSD). It offers a critical gaze on some of the extant expert knowledges that CoPs mobilise and aims to make visible the power relations of the discourses which resource their therapeutic talk.

Therefore, I use a post-structuralist epistemological approach to answer the research question: *"What are the discursive power relations in counselling psychologists' therapeutic accounts of working with male sexual dysfunction?"*. Ten CoPs with experience of working with clients presenting with MSD were asked to talk about their understanding and experience of the phenomenon. The interview transcripts were analysed using a Foucaudian Discourse Analysis (FDA) and the therapeutic accounts were interrogated to unmask discursive power games and relations. This research aims to contribute to the development of CoPs' reflexive and critical practice as providers of psychological and therapeutic care to individuals.

In this first chapter, I provide the context and rationale for this research by situating counselling psychology as a distinct discipline in psychology and the tensions concerned with its postmodern ethos. Secondly, I problematise MSD by illustrating it as a mutable category that is diversely resourced by biological, psychological and therapeutic accounts. MSD is seen as of interest to CoPs due to its reported prevalence in the general population and its presentation across a range of physical and mental health services where CoPs may be located. This line of inquiry is further warranted by the paucity of research related to MSD within the counselling psychology domain to date. Lastly, this chapter concludes with a justification of the post-structuralist Foucauldian perspective applied throughout this research, providing a context for the genealogical analytic applied to extant related literatures in Chapter Two.

1.2 The liminal space of counselling psychology

This section provides the context of this research by locating the profession of counselling psychology and its distinctive identity in the broader psychological and mental health field. This explication of the field illustrates the tensions associated with its philosophical foundations.

Counselling psychology in the United Kingdom is a comparably new discipline in the psychological and therapeutic professions, emerging in the 1960s as a specialist interest of psychology and becoming a distinct division of the British Psychological Society (BPS) in 1994 (Strawbridge & Woolfe, 2010). This discipline developed as a distinct space in psychology with concerns and interests different from the dominant positivist psychology of the time by emphasising humanistic values, a holistic approach to mental health and a focus on the subjective rather than the objective (Orlans, 2013; Woolfe 2012).

From an epistemological perspective, counselling psychology is distinctively inclusive of diverse paradigms in contrast to the mainstream realist tradition. This is illustrated in counselling psychology's refusal to align itself with a single therapeutic modality (Kasket & Gil-Rodriguez, 2011) and as such, CoP training incorporates knowledge of medical, psychological, humanistic, psychodynamic and cognitive-behavioural approaches to clinical work. The embrace of multiple psychological and therapeutic models positions the CoP as a flexible psychological practitioner equipped to work with diverse problems and in a range of settings (Strawbridge & Woolfe, 2010). The application of these therapeutic knowledges and practices may be applied in a variety of ways, such as eclectically or integratively (Lapworth, Sills & Fish, 2001), or pluralistically (McLeod & Cooper, 2010).

Such variety also has its limitations which are notable in some of the tensions identified. For example, Rizq (2006) reports that the postmodern identity of counselling psychology poses significant difficulties for trainees as they encounter theoretical and clinical diversity, confront the associated contradictions between the competing perspectives, and the trainee's desire for certainty. A further tension distinct to the counselling psychology discipline noted by Woolfe (2012) makes visible the contradiction between the CoP as scientist-practitioner while also striving to incorporate the reflective-practitioner role. Such contrary interests of empiricism and attention to subjectivity could potentially create problematic tensions and possible confusion in CoPs' therapeutic thinking and practice. Given such issues, it is important this proposed research strives to recruit CoPs to see if their therapeutic accounts of working with MSD reflect such dilemmas.

1.3 Problematising male sexual dysfunction

Just as there is a multiplicity of approaches in CoP, how MSD is understood in medical, psychological and psychotherapeutic domains also offers diverse perspectives. Although there appears to be one dominant definition currently in circulation from the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association [APA], 2013), this too poses particular challenges. The current DSM-5 defines MSD as a:

“heterogeneous group of disorders that are typically characterised by a clinically significant disturbance in a person’s ability to respond sexually or experience sexual pleasure” (p. 423).

This umbrella definition focuses on a “heterogeneous” range of difficulties glossed as “significant disturbance” that produces a range of symptoms as abnormal and implicitly contrasts with what is understood as a normal sexual response. Interestingly in contrast to previous versions of the DSM “sexual pleasure” is privileged in this version, which also illustrates the mutable nature of how behaviour is defined and pathologised (see Chapter Two, section 2.3.4). Conceptualising the DSM as socially constructed rather than reflecting reality has been noted by Kutchins & Kirk (1997) who highlight the political influence of this resource in making visible and obscuring particular presenting issues, such as MSD.

From a critical perspective, current and past definitions of sexual dysfunctions used by the DSM have been questioned by sexologists and researchers for their categorical classification system, marginalisation of psychological and relational factors, as well as remaining focused on heteronormative penis-in-vagina

penetrative sex (Kleinplatz, 2012). The development of these changes and terminology in the DSM are addressed further in the Chapter Two and is briefly mentioned here to illustrate that even within the same diagnostic model MSD has not remained static or universal, but historically contingent.

While MSD is the contemporary term of this presenting problem, over the course of the twentieth century there have been a number of terms such as 'impotence' and 'psychosexual disorder', which were subsequently abandoned, possibly due to their psychoanalytic allegiances. Furthermore, an overview of the various therapeutic accounts of MSD during the twentieth century highlight diverse and competing explanations and treatment recommendations both within biological and psychological domains. For example, within the psychological and psychotherapeutic disciplines psychoanalysis dominated the treatment of MSD for the first half of the twentieth century (McLaren, 2007). The emergence of behavioural and cognitive-behavioural models in the late 1960s and 1970s then prevailed, and continues to do so, as the psychological treatment of choice for MSD (Berry, 2013). However, the development of pharmaceuticals in the 1980s effective for treating certain subtypes of MSD became associated with the medicalisation of MSD, placing primacy on the biological and physical aspects of male sexuality and function, rather than attending to the social and psychological (Tiefer, 2006, 2012) and situated medical professionals as best placed to provide help. These competing therapeutic claims appear to still have valence and are evidenced in the literature of 'best practice' which advocates the inclusive biopsychosocial model of MSD (Berry & Berry, 2013). As such, these diverse expert knowledges may pose a challenge for any practitioner presented with MSD, and in particular CoPs, who are already subject to a range of therapeutic accounts.

From the above evidence, it is clear that for psychological practitioners, and CoPs in particular, working with clients who present with MSD locates them in wider challenges of definition, competing therapeutic models and power struggles with other expert professionals.

1.4 MSD in counselling psychology

The question may be asked – why do CoPs need to be concerned with MSD?

Due to the expansive and diverse models that CoPs are trained in they are employed within a variety of work places and sectors (Strawbridge & Woolfe, 2010). Therefore, CoPs are considered resourceful and flexible mental health practitioners, applying their diverse psychological and therapeutic knowledges to an array of mental health problems and contexts. In conjunction with men seeking help for MSD across a range of services (both generalist and specialist) and sectors (private, third sector or statutory) as well as high reported prevalence rates within the population (Cromby Harper & Reavey, 2013) it is likely that CoPs may encounter MSD in their clinical work. For example, as a trainee CoP I encountered clients with MSD whilst on placement in a National Health Service (NHS) primary care counselling setting, as well as a charitable organisation specialising in sexual health. Therefore, I argue MSD and its therapeutic treatment is a relevant problem account for CoPs to consider because of the multiple contexts and services clients may present in.

Furthermore, CoPs need to consider MSD due its presentation as a primary or secondary problem and its potential wider effect on an individual's wellbeing. For example, research indicates MSD is often associated with other mental health issues such as relationship difficulties, quality of life, mood disorders and self-

esteem problems (Abraham, Symonds & Morris, 2008; Chevret, Jaudinot, Sullivan, Marrel, & De Gendre, 2004; Rosen et al., 2004). As these are common concerns that CoPs may often work with it is important to consider the possible role and interaction of sexual function in these presenting male clients.

In relation to the diverse work place settings CoPs may be positioned in it is important to consider the possible influence of the ideological position and context they operate in. For example, the NHS, the largest provider of mental health and psychiatric care in the UK, will employ many CoPs. However, the NHS's application of a medical model to human distress is often contradictory to the humanistic and relational epistemologies underpinning counselling psychology (Woolfe, Strawbridge, Douglas & Dryden, 2010). This may pose particular challenges to CoPs in how they negotiate their professional identity and practice. The NHS's mandate to provide evidence-based practice drawing on empirical enquiry may constrain or limit a CoP's choices for therapeutic intervention. This is highlighted by cognitive-behavioural therapy (CBT) being the model of choice for many mental health concerns currently, due to its research-friendly and protocolised nature, as well as cost-efficiency incentives (House & Loewenthal, 2008).

Examination of the extant literature and research on MSD appears to locate it in the domains of sexual medicine, sexology, and sex therapy, indicating a relative dearth on this topic in counselling psychology. As argued above MSD is a relevant clinical topic that CoPs may encounter in their professional life and therefore it is important to provide research addressing the specific complexities they may engage with. As such this research aims to contribute to the limited research base in counselling psychology addressing MSD and aims to offer a

useful resource that may inform CoPs' clinical thinking and practice; a tenet of relevant quality research as proposed by Orlans (2013).

In summary, the main reasons for conducting this research are as follows. Firstly due to CoPs being pluralist or integrative practitioners they are multiply resourced to understand and work with MSD yet there may also be tensions and difficulties which this proposed research will address. Secondly, the circulation of multiple and diverse therapeutic accounts of MSD may similarly present specific difficulties for CoPs when working with this problem account. Thirdly, it is argued that due to the complexity of these heterogeneous understandings a CoP working with MSD may be subject to a critical approach to their own truth claims could be beneficial, which a Foucauldian discourse analysis can address. Therefore, this research adopts a post-structural epistemological approach, which is now outlined.

1.5 Post-structuralism and this proposed research

This research adopts a post-structuralist epistemological stance that focuses on language used by CoPs in relation to their understanding and work with MSD, which as illustrated above is a complex and mutable construct. By adopting a Foucauldian discursive approach, the analytic interest will be in language as discourse and its power relations for what is worked up as true and objectified and by implication silenced and prohibited by participant CoPs.

Post-structuralism is a collection of ideas that came to prominence in the 1960's and 70's as a critique of modernism and a development of structuralist thought. Post-structuralism challenges post-Enlightenment modernist claims to an objective reality that can come to be known via empiricism and the scientific method; an endeavour which continues to dominate and influence traditional psychology

(Burr, 2003). Both structuralism and post-structuralism argue that our understanding of the world is always mediated via language and representation, and therefore, language constitutes our reality rather than simply reflecting or describing it. As such, they are considered anti-essentialist, assuming nothing pre-exists language waiting to be discovered. However, post-structuralists, unlike the structuralists, claim meanings and language are mutable, dynamic and dependent on the socio-historical contexts in which they are bound. Social processes are glossed as the actions in which language and meanings are transmitted and co-constructed and inextricably bound with knowledge and the constitution of reality (Gergen, 1985).

In adopting a post-structuralist epistemological position for this research MSD is argued not to pre-exist prior to language and that notions of MSD and its treatment are a product of social processes and interaction. As such, this research privileges the claim that knowledge is discursively generated, and consequently does not seek to discover the 'truth' of MSD, but rather aims to explore the various therapeutic 'truths' in the talk of CoPs in their work with MSD. Of particular interest to this research are the discursive power relations associated with particular accounts of MSD in the context of counselling psychology, in what may be worked up as 'true' and whose interests these relations serve.

1.6 The turn to language and Foucault's gaze

This research draws on the radical post-structuralist thought of cultural philosopher, Michel Foucault, who emphasises the power of language in the social construction of reality. He illustrates his ideas by interrogating the discursive construction of concepts such as 'madness', 'discipline' and 'sexuality' (Foucault, 1965/1988, 1975/1988, 1978/1998, 1985/1992, 1986/1990). Foucault's

application of archaeological, and later genealogical methods, problematised these 'objects' allowing him to trace the 'history of the present' and interrogate the social processes through which the discursive object came into being (Bacchi, 2012).

Of particular relevance to this proposed research are Foucault's ideas expressed in his trilogy *The History of Sexuality* (1978/1998, 1985/1992, 1986/1990) where he problematises sexuality by interrogating how it was practised and socially regulated in different historical contexts. In these publications Foucault highlights the productive and mutable power of language as applied to sexuality, and its implications for social regulation in addition to self-regulation. The latter of these works marked an important shift in his thinking and development of his ideas on the production of an individual's subjectivity, their resistance practices and the ability to critique and self-form.

Foucault uses the term discourse not to describe 'objects' but argues that discourses are "practices that systematically form the objects of which they speak" to which we then become subject to. (Foucault, 1972, p.100). A discourse can therefore be thought of as a group of statements that set up relationships with other statements to produce meanings and effects in the world by constituting a particular version of reality and define what is 'truth' at particular moments (Carabine, 2001). As such, Foucault argues these productions of knowledge or 'truth' facilitate or constrain what can be said and by whom and are multiple, relational and mutable. As such he is interested in the discursive practices and the 'games of truth' which produce particular perspectives of the world which become privileged as 'true' (Danaher, Schirato & Webb, 2000). This focus between knowledge and power (often referred to as power/knowledge)

emphasises knowledge as both constituting and constituted through discourse as an effect of power (McNay, 1994).

Foucault's issues of knowledge and power are considered to be of critical importance to counselling psychology as discourses are relational, with some having more power than others, and deemed to have more authority or validity related to the specific knowledges they deploy. For example, particular discourses or institutions that are socially accepted as professional or 'expert', such as medical or psychological discourses are seen to have the authority to define what is normal or pathological. These 'dividing practices' (Foucault, 1972) establish divisions between individuals and social groups, implicating the subject within a set of normalising assumptions. Foucault illustrates with his genealogies how discourses convey messages about what is the norm and what is not, and how these are reified as cultural norms which then come to regulate individual's behaviour (McNay, 1994). Therefore, of particular importance to this research is the power relations associated with expert discourses which make visible and exclude specific understandings of reality that CoPs may be subject to and perpetuate.

As this research is concerned with the discursive power games contingent in CoPs therapeutic accounts of working with MSD Foucault's conceptions of power are important to examine. Foucault contested mainstream notions of power by claiming it to be relational, embodied and exercised rather than possessed (Danaher et al., 2000). From his discursive perspective he proposed knowledge exercises power by constructing people as subjects, by which they then become subject to that knowledge, as to make sense of themselves they have to refer back to various knowledges (McNay, 1994). Initially Foucault (1965/1988)

considered power to be exercised strategically and negatively, mainly exercised by controlling and dominating subjects via coercion and oppression. These mechanisms of power could be seen in the overt practices of public hangings to the more subtle operations of disciplinary power (Foucault 1975/1988). Such disciplinary power is exemplified by the self-surveillance practices induced by Bentham's Panopticon in the penal system to bring about inmate self-discipline.

As power is relational, resistance became a central concept in Foucault's work: "Where there is power, there is resistance" (Foucault, 1978/1998, p.32). In his early conception of strategic power, resistance practices were perceived as directly opposed to the hierarchical power direction, which Thompson (2003) calls 'tactical reversal'. However, Foucault found the reliance on a negative relation of power insufficient both historically and conceptually to account for the workings of social power and individual subjectivity. This led to Foucault's reconceptualisation of power as governmental, emphasising power not as force but as the guidance of an individual's behaviour or the 'conducting of conduct'. Governmental power is implicated in the truth telling of the confessional self (Foucault, 1977/1980) and the techniques people use to understand and manage the self (Foucault, 1985/1992, 1986/1990). This nuanced mechanism of power provides a more robust explanation of how individuals construct themselves towards socially available discursive knowledges and how they become subjectified and self-regulating subjects. This productive form of power therefore necessitated a different form of resistance via the practice of critique and self-formation which allows Foucault to provide a richer understanding of subjectivity.

Foucault's four conceptions of power are utilised throughout this research to highlight the power relations operating in CoPs' therapeutic accounts of working

with MSD. The following section presents three key analytic concerns that are sustained throughout this research to interrogate the power games in CoPs' talk of working with MSD.

1.7 The post-structuralist analytic as applied to MSD in counselling psychology

Firstly, in applying Foucault's post-structuralist stance, as detailed above, an anti-essentialist approach to the phenomenon of MSD is adopted. In the vernacular, male sexual function and dysfunction, may be talked about as a 'natural' or given, but in this research it is considered to be a discursively constructed 'object'. Therefore, how MSD is objectified and constituted within matrices of power relations will be a focus of this research. This will also involve examining the related discourses that provide frames of intelligibility such as constructions of male sexuality and identity.

Secondly, in interrogating the therapeutic talk of CoPs in working with MSD, this research aims to identify the expert discourses which may resource their accounts eg. medical, psychological and therapeutic discourses. In doing so, each will be explored to see what understandings in relation to MSD and its treatment are afforded and prohibited. This critical perspective is important as, in the post-structuralist tradition, mainstream psychological and therapeutic knowledges have been criticised by Parker (1999), Rose, (1985) and House (2003) for producing and reinforcing dominant social values and norms. Therefore this research aims to offer a critical approach to the power-laden therapeutic knowledges that are circulating and available to discursively resource CoPs' therapeutic work with MSD.

Furthermore, a critical approach to these knowledges and power relations are of significance to CoPs as the Health Care Professional Standards Commission (HCPC, 2012) stipulate that all practitioners must be attentive to the power imbalances between practitioners and the clients they treat. From a discursive perspective this means interrogating the implications of privileging certain understandings over others and what is made possible and what is shut down. This potential hierarchical power relationship also emphasises the need to consider how CoPs are discursively positioned in relation to clients and other 'expert' health professionals and disciplines by the discourses they may be subject to.

Lastly, and unsurprisingly, subjectivity is an especially important concern for CoPs and became an increasing focus for Foucault in his later work. Foucault's (1985/1992, 1986/1990) post-structuralist stance unsettled humanist assumptions of a singular, unified self and proposed that subjectivity or ways of being are created within and between discourses (Hook, 2007). Within these complex power relations subjective experience and identities are shaped allowing the individual particular ways of experiencing the world. Just as discursive objects are constructed so are subjects (e.g. the 'pervert', the 'patient'). Although an interrogation of subjectivity is speculative (Willig, 2013) it is seen as an imperative for this investigation into the power relations in CoPs working with MSD. Examination of the subject positions that are enabled and constrained by particular discourses and the duties and rights they may afford offers another critical focus for CoPs. Increasing awareness of CoPs to the power games their talk discursively locates them in may allow them to knowingly reposition or mobilise other subjectivities.

1.8 Overview of the aims and potential contribution of this research

This chapter has problematised the diagnostic category of MSD by illustrating its mutability and the diversity of therapeutic knowledges resourcing it across professional disciplines. MSD has been argued to be a common presenting problem within Western culture and a likely issue that CoPs may be presented with in their clinical work. Troubling essentialist notions of MSD, I have argued that a discursive perspective applied to this problematic therapeutic object is of interest to counselling psychology.

Applying a post-structuralist perspective to this research aims to alert CoPs to the discursive rules that may shape their therapeutic understandings and clinical work with MSD. Through the analysis of discursive resources that CoPs draw from I aim to raise their awareness of the power relations they may be embedded in and provide a critical perspective to the regimes of truth they may be unknowingly subject to.

In order to address the interests of this proposed research, in Chapter Two I offer a critical review of relevant literature and research by adopting a genealogical perspective. Chapter Three details the post-structural epistemological position, methodology and method employed in this research. Chapter Four presents the analytic findings of a Foucauldian Discourse Analysis (FDA) as applied to 10 counselling psychologists' therapeutic accounts of MSD. Lastly, Chapter Five concludes this research with a discussion of the findings, possible contributions to the field of counselling psychology and an evaluation of the research.

Chapter Two

Genealogical Perspective of Male Sexual Dysfunction

“One undergoes a genealogical text as a knower, and one does not emerge the same”

McWhorter, 1999: pp. 50.

2.1 Introduction to Chapter Two

The aim of this chapter is to critically review related literatures to the social, biological, psychological and therapeutic approaches to MSD in Western culture, which is the central concern of this proposed research. This will be achieved by presenting a genealogy of various historical uses of the term that resource its present therapeutic conceptualisation by CoPs. A genealogical approach specifically traces the historical discursive emergence and descent of a phenomenon, such as MSD, and its relationship to various wider social constructions e.g. sex and male sexuality (Foucault, 1978/1998; Malson, 1998). For the purposes of this research it is argued that the phenomena of MSD does not pre-exist language but is constituted through social meaning and practices. Therefore, this genealogy’s purpose is to highlight the discursive power relations in the objectification and problematisation of MSD as a presenting problem to CoPs.

The structure of this genealogy addresses pre-psychological, psychological /therapeutic and contemporary knowledges of MSD by applying the following three analytic interests. Firstly, this analytic gaze unmask the wider contextual politics of sex and masculinity in Western culture. Secondly, this perspective examines

the objectification of MSD and its related power relations for subjectivity across these domains, and thirdly, how this phenomenon changes in its construction and therapeutic treatments down the ages.

2.2 Pre-psychological constructions of MSD

Pre-psychological constructions of sex and MSD are worth exploring due to their discursive legacy as a history of present uses, particularly attending to practices from Ancient Greece and Rome, followed by the dominant influence of the Christianisation in the West. Lastly, the discursive practices and power games of MSD during the Enlightenment are interrogated as a precursor to the emergence of psychological knowledges in modernity in Western society.

2.2.1 MSD in Ancient Greece and Rome

Earliest written records from Antiquity indicate that man and his sexual potency have always been an important concern in Western culture (McLaren, 2009). Sex was objectified as a generalised activity, akin to eating and drinking as opposed to it later being associated with a personal sexual identity (Weeks, 2016). In this era there seemed to be a preoccupation with virility as masculinity that produced a mono-discourse of what it meant to be a “real” man.

Management, moderation and self-mastery were privileged rather than self-denial as penetrative performance was highly valued and denoted social standing e.g. sexual access to women, slaves, and boys (McLaren, 2009). This resonated with the dominant humoral view of bodily functions and the need for balance to maintain health. In addition, it discursively produced the active vital man as performer, which seemed to be the norm for masculinity at that time (Golden & Toohey, 2011).

As well as biological humoral causes, this society was also governed by metaphysical discourses to understand such problems in daily life. A variety of supernatural causes for issues with desire and sexual problems were sometimes understood as related to spells or angering the gods (McLaren, 2009). Mystical solutions in the form of amulets, talismans and prayer were recommended by elders to remediate such difficulties in men. Interestingly, there is evidence of ancient healers combining the biological herbs and plant restoratives with sympathetic magic of metaphysical rituals to create a potent alchemy to address this problem.

Considering the discursive legacy of this era, we seemed to have retained the idea of masculinity as being valued, active, performative and penetrative. This phallocentric worldview (Butler, 1990) is still evident in contemporary Western culture, particularly in 'alpha male' gendered discourses. Examination of this period, agrees with Rider's (2006) comments, that MSD appears to remain glossed as an illness to be cured and categorised in the reductive binaries of health/illness, normalacy/abnormalacy and natural/unnatural. This influential objectification of MSD appears to continue to produce this phenomenon as a problematic condition, requiring restoration and positioning the sufferer under sanctioned experts in a hierarchical helping relationship. Lastly, MSD appears to still be constructed in corporeal terms (i.e. biological constructions) or by metaphysical explanation (i.e. beyond the physical body). As will be addressed in more detail below, contemporary metaphysical approaches, have mutated from religious understandings and replaced by secular psychological knowledges.

2.2.2 MSD in the Christian West

With the emergence of Christianity as a dominant belief and value system in Europe around 313 AD, sexuality was reconfigured as a base impulse of 'the flesh', dangerous and requiring social regulation (Cromby, Harper & Reavey, 2103). Contrary to Antiquity, that discursively produced sexual matters as part of everyday life and linked to social status, this turn to Christianity constructed sex as just for procreation and in opposition to a developed spiritual life now and after death. To accomplish this social regulation attention to the individual and the private practices of the self were managed in social institutional practices of the confessional, the institution of marriage and the valorisation of self-denial in monastic celibacy.

In this period, the construction of sex as inherently sinful was an influential discursive practice as sexual behaviour constituted one's moral and psychological interiority (Foucault, 1977/1980). Sexual desire became objectified, vilified and problematised. In contrast to Antiquity where sexual balance was the goal, the Christianisation of sexuality lauded self-denial and celibacy, redefining idealised norms of masculinity (McLaren, 2007). Therefore sex became only permissible for procreative purposes, rather than personal pleasure, and a necessity for the consummation of marriage whose main purpose was for reproduction.

Foucault (1977/1980, 1982,) argues that the development of pastoral power evident in the Roman Catholic 'confessional' was an influential discursive practice whereby an individual was compelled to tell their private 'truth' to a priest, particularly in relation to their sexuality. This practice, Foucault argues regulates by individuals becoming subject to their own confession and self-policing their private thoughts and behaviours (Danaher, Schirato & Webb, 2000).

With marriages rendered void by lack of consummation, MSD became a political, familial and economic matter. As such churchmen were granted powers in the 13th century to inspect male and females to validate claims of unconsummated marriages (McLaren, 2009). As the Church elevated themselves as an authority of religious and sexual union, Canon lawyers drew on Greco-Roman accounts of anatomy to aid their parishioners. Again, humoral theories of the male sexual organs prescribed foods and herbs to redress imbalances and provoke desires. Within Christian discourses of sexuality, a causal link between sin and sickness was created. Failures of men to have sex were accounted for as divine punishment, the test of God or demonic forces (McLaren, 2007).

The discursive inheritance of this era may be seen in contemporary moralistic constructions of sex, contributing to its taboo and private nature (Butler, O'Donovan & Shaw, 2009). From this period male sexual function seems to become embedded within heteronormative monogamous relations that emphasise sex as penis-in-vagina (PIV) intercourse and arguably continue to regulate understandings of sexual activity and function in the contemporary West. Sexuality as the 'truth' of an individual's identity remains a dominant discursive practice in contemporary Western culture, as has Foucault's (1977/1980) notion of the confessional self, which is of particular relevance to CoPs as providers of psychotherapy.

2.2.3 The Enlightenment and pre-cursors to psychological constructions of MSD

The Enlightenment, dating from the end of the seventeenth century and early eighteenth century is identified by the political upheaval of the French revolution in which the traditional hierarchical religious, political and social orders (the French

monarchy, French nobility and the Catholic Church) were violently destroyed and replaced by a political social order informed by the Enlightenment ideals of freedom and equality based on the principles of human reason (Walsh, Teo & Baydala, 2014). The epistemological and methodological shift of the Enlightenment to a new science saw metaphysical explanations, associated treatments and spiritual leaders' authority lose influence in Western culture.

Generally through the eighteenth century and nineteenth centuries the medical establishment claimed authority over sexuality and the treatment of sexual issues primarily adhering to physiological models of treatment (Atwood & Klucinec, 2007). This societal change saw the development of the discursive practices of documentation, categorisation and medicalisation for a variety of phenomena and thereby implicated in regulation of individuals and populations. Foucault's (1978/1998) interrogation of the emergence of the '*Scientia Sexualis*' illustrates how this categorisation extended to the domain of sexuality in the context of the 'Great Confinement' and psychiatry becoming a distinct medical discipline in the West in the 1800s with greater control and management of the 'mad' in the following hundred years.

Two influential medics are of note from this period that highlight the applied scientific gaze and interest to sex, sexuality and its problems and therefore of interest to this research. Although resourced by a biological discourse of MSD these figures additionally highlight a discursive precursor to the dominant psychological understandings of MSD that then prevailed in the twentieth century (Berry, 2013).

With new and different physiological understandings of the body John Marten's (1709) *Gynosologium Novum; or A new System of All the Secret Infirmities and Diseases, Natural, Accidental, and Venereal in Men and Women* (cited in Berry (2013)) constructs male impotence as physiogenic in cause, as opposed to previous religious discourses of sin or Satan. Although his biomedical explanations of MSD bear little resemblance to contemporary physical discourses it does mark a shift of MSD to the increasing cultural power that scientific explanations of the body had on being legitimate 'experts'. Marten (1709) utilised this medical expert position to legitimise the claims of his restorative tonics and aromatics over the proprietaries of non-medics/quacks and benefited financially.

Although physiological causation of MSD and its remediation was a preoccupation of Marten's (1709) work he also drew on a psychogenic discourse, attributing emotional states such as 'grief' and 'fear', and the processes of 'over-thoughtfulness' and 'study' as implicated in producing MSD. This discourse appeared subjugated by the biological accounts of MSD of the time but does highlight a precursor to future psychological constructions.

Research suggests that in the latter part of the 1800s, psychiatry began to concern itself with sexual problems, reflecting both psychiatry's emergence as a discipline and a growing psychologically-orientated understanding of sex (McLaren, 2007). However, early psychiatric discourses of MSD relied specifically on the physiology of the brain and the nervous system to account for MSD, which provided the foundation of physiatrist Krafft-Ebing's (1886/1965) publication *Psychopathia Sexualis*. This influential text classified sexual perversions and aberrations, and deployed psychopathology to define what was considered 'normal' and 'abnormal' towards sexual activities and sexual functions. This

psychopathologisation of MSD remains evident in contemporary diagnostic manuals (see section 2.3.4) and utilised by mental health practitioners, such as CoPs, and therefore the discursive practices of the medical model of disease and disorder of significance. Krafft-Ebing (1886/1965) claimed that the problems now known as MSD were physiogenic in origin and thus attributed to 'neuroasthenia' (nervous illness) and to 'cerebral neuroses'. Locating difficulties with recourse to neurological and neuropsychological explanations is a current trend in psychiatry, psychology and psychotherapy (Schore, 2014) and appears to gain cultural value through its biological materialist claims.

Similarly, to Marten (1865), Krafft-Ebing (1886/1965) also notes psychological precursors of MSD. For example: "The erection centre may become incapable of function through cerebral influences. This inhibitory influence is an emotional process (disgust, fear of contagion), or fear of impotence" (Krafft-Ebing, 1886/1901, p. 45). Discursively, Krafft-Ebing reifies sexual function in a spatial metaphor of the brain that is 'the erection centre'. This 'centre' is then 'inhibited' by negative affective states which subsequently cause MSD. In this description, the relationship between the mind and body is considered, which is in opposition to prevailing binaries of the mind/body, and echoes a more nuanced account that is addressed in the contemporary biopsychosocial model of MSD (see section 2.3.5). 'Inhibition' tacitly implies sexual function as 'natural' and 'normal' and implicates dysfunction in a pathologising discourse. Interestingly the causative 'fear of impotence' discourse remains prevalent in contemporary CBT accounts of MSD (see section 2.3.2).

The Enlightenment's contribution to the development and professionalisation of medicine, and then psychiatry, as privileged experts of health and pathology

continues in Western society. Their continued application of the scientific method to sexuality and its problems, the methodical approach to cataloguing and description, and the deployment of a pathological discourse are discursive legacies of this era. Although psychological pre-cursors were evident these appeared limited and subjugated in contrast to the dominant circulating medical accounts. However, it is Freud's introduction of his psychoanalytic theory that constructs psychological understandings of MSD that then came to dominate treatment of this issue for over half of the twentieth century.

2.3 Psychological knowledges and their construction of MSD

The turn of the twentieth century saw the beginning of the West's concern and preoccupation of psychological understandings of the individual. This century saw the proliferation of psychological and psychotherapeutic understandings of human life and their problems and therefore of particular relevance to CoPs as psychological practitioners. This section will interrogate some of the psychological and therapeutic knowledges that construct MSD commencing with Freud's psychoanalytic theory, and trace the development of other discursive practices and theories of MSD to the present day.

2.3.1 Freud's psychoanalysis and MSD

Sigmund Freud's landmark theory of psychoanalysis came to prominence at the turn of the twentieth century producing a new language of which to talk about the mind, sex and difficulties in individual's lives. Freud's conceptualisation of the psyche placed all psychopathology, MSD included, as psychogenic in origin underpinned by disruption or arrest in his proposed linear psychosexual developmental pathway. The psychoanalytic discourse became so influential that all cases of MSD were constructed as psychological in origin and treated by

psychoanalysis from the 1900s until the late 1960s (Berry, 2013; McLaren, 2007). Although traditional psychoanalytic theory and practice has mutated its ideas continue to inform contemporary psychological and psychotherapeutic practice in the West and therefore worth further consideration.

Freud developed his practice of psychoanalysis within the Victorian era, which is commonly assumed to be a period of sexual repression and taboo. However, Foucault (1978/1998) disagrees with this 'repressive hypothesis' and argues that this time was characterised by sexuality becoming an intense object of discursive interest. For example, children's, women's and deviant sexualities were sites of scrutiny and led to many practices in an attempt to control and regulate certain sexual behaviours. Freud appears to have contributed to this 'repressive hypothesis' by constructing all psychological life as derived from the life/sexual drive whose 'true' expressions were relegated to the unconscious because they were 'threatening' and 'unacceptable'. From a discursive perspective, the glossing of sexual desires and impulses as 'dangerous' implies the overwhelming and disruptive nature of sexuality and thereby in need of control.

Freud's theories may be considered a product of the patriarchal and heteronormative society he grew up in and perpetuated by his privileging the power of the phallus and constructing opposite sex attraction as successful development. Interestingly, despite Freud and his followers focussing on the role and power of the phallus, little was written specifically with reference to MSD except a reference made by Freud within the '*Three Essays on the Theory of Sexuality*' (1961a), '*On the Universal Tendency to Debasement in the Sphere of Love*' (1961b) and in the preface to Steiner's '*The Psychical Disorders of Male Potency*' (1961c). At first Freud proposed that masturbation in youth would lead to 'psychical impotence' in

adult life, but subsequently glossed impotence as difficulties negotiating the Oedipus complex or an arrest in childhood development (Berry, 2013). For Freud functional male sexuality required the integration of the 'sensual' and 'affectionate' currents in the unconscious: "where they love they do not desire and where they desire they cannot love" (Freud, 1912/1961a, p. 183). Conflict between these two elements was theorised to result in sexual dysfunction, and again, discursively produced sexuality as problematic in this reductive linear developmental pathway.

Freud's psychoanalysis aimed to return potency to men via an analysis focussed on making unconscious conflict conscious and resolve arrests in the individual's development. This was often a lengthy and expensive treatment that was not symptom orientated but focussed on global character change. By privileging intrapsychic processes this psychoanalytic perspective excluded possible biogenic explanations and interventions towards the body. His deterministic stance of childhood development may have offered reductive views of the impact of current relational issues and positioned the analyst as the 'expert' on the individual's psychological workings, with recourse to 'defence mechanisms' to legitimate disputed therapeutic claims.

Freud's discursive legacy is evident in the proliferation and professionalisation of the 'talking therapies' as a way to treat and think about problems. Although no longer the dominant psychotherapeutic treatment for MSD, classical psychoanalytic constructions continue to inform psychodynamic approaches to MSD. For example, the focus on unconscious dynamic forces, the deterministic effect of early childhood experiences on adult functioning and the relationship between therapist and client as a vehicle for healing.

Freudian psychology was problematic for the increasing power of science and its empirical measurements in the twentieth century. This shifting in power relations from one paradigm to the next is highlighted specifically in the construction of MSD and its treatment approach.

2.3.2 Twentieth century empirical approaches to sexuality and MSD

During the middle years of the twentieth century discussion moved from clinical cases of male sexual problems to empirical positivist research aiming to establish normative trends of sexual activity in populations. This occurred within the context of shifting gender relations post-war, increasing power of consumerism and the political contestation provided by the feminist movement in the 1960s and 1970s (McLaren, 2007). The realist approaches of Kinsey, Pomeroy and Martin (1948) and Masters and Johnson (1970) are worth examining as they radically shaped lay and expert understandings of sexual behaviours and MSD, and continue to do so in contemporary thinking and practice.

In contrast to the psychiatric and psychoanalytic focus on 'deviant' sexualities and pathological sexual problems Kinsey et al. (1948) aimed to quantitatively establish the 'normal' sex lives of Americans. Their surveys of thousands of interviews with Americans about their sex lives contested previously held assumptions about sexual activity e.g. 60% of the sample interviewed reported some form of same-sex sexual activity challenging long held notions of this being 'rare'. From their research Kinsey et al. (1948) made generalisable claims to the decrease in sexual functioning over life span, glossed notions of premature ejaculation as a non-pathological response and constructed sex as a sign of maintaining health, contesting previous seminal economic theories and the dangers of excess sex (McLaren, 2007). These sexologists' research, however, glossed sexual

‘success’ and ‘function’ to reductive achievement of orgasm, which remains a contemporary discursive practice in some expert knowledges and in the public domain. This realist quantitative approach remains the dominant paradigm for investigating MSD in the fields of medicine, psychiatry, sexology and psychology and informs therapeutic treatment, epidemiological research and service planning and provision.

In contrast to Kinsey et al. (1948) who focussed their attention on epidemiological concerns of sexual behaviour Masters and Johnson (1966, 1970) utilised the scientific method and advances in technology to observe, categorise and record the physiological processes of sex. Their work emerged from the increasing popularity of CBT in the late 1950s and 1960s and its displacement of the psychoanalytic paradigm, and also associated with diminished interest in MSD by psychiatrists but growing interest by psychologists. CBT drew on conceptualisations of the mind as information processors displacing the unknowability of the psychoanalytic unconscious, and offered time limited therapy, economic incentives and therapeutic efficacy (Berry, 2013).

From their observational studies Masters and Johnson (1970) constructed a generalised model of sexual functioning called the ‘human sexual response cycle (HSRC)’, and classified the stages into the discrete phases of ‘excitement, plateau, orgasm and resolution’. Disruption or ‘inappropriate’ responding of this normative cycle indicated sexual dysfunction. However, the genitally focussed HSRC cycle neglects the body in its totality and fragments the male’s anatomy and its processes, with different parts coming in and out of the sequence (Kleinplatz, 2001). The use of reductive mechanical metaphors of a machine in disrepair foster a myopic view of sexuality. In the case of sexual difficulties each

part (of the HRSC) could be systematically checked to detect the component that is failing and restored to perfect functioning. From a discursive perspective this generalised model emphasises performance and seemingly neglects the subjective meaning and experience of the individual involved (Kleinplatz, 2001).

This CBT account of MSD mobilised psychological explanations but emphasised the disruptive role of anxiety in producing dysfunction, for example 'performance anxiety' in the case of erectile dysfunction. Reifying cognitions, emotions, and behaviours as different aspects of an individual's experience allowed Masters and Johnson (1970) to target these for change via behavioural interventions, psychoeducation and cognitive restructuring (Berry, 2013). In line with the empirical paradigm Masters and Johnson (1970) measured outcomes to legitimise and publicise the efficacy of their treatment of MSD, claiming their 'squeeze technique' cured 182 out of 186 cases of premature ejaculation. In contrast to psychoanalytic discourses that positions the client in a fairly passive role in treatment, CBT actively engages the client to be a collaborative partner. Psychoanalysis privileged the unconscious whilst CBT privileges the conscious mind. In general, CBT has been viewed as reducing power inequalities between therapist and client but considered a powerful mechanism of normalisation and highly politicised treatment modality in current mental healthcare provision (Loewenthal & House, 2008).

In summary, Masters and Johnson's (1970) discursive legacy has been the reification of 'Sex therapy' (see section 2.3.7) as a distinct and professional discipline, and the continued application of their treatment methods from the 1970s to the present day (Althof, 2010). In their therapeutic treatment of MSD they could be considered as privileging sexual performance at the expense of

subjective meaning and experience, prioritising the goal of therapy to symptom removal, and promoting generalised sexual norms at the expense of individual uniqueness. This displacement of one therapeutic paradigm by another is of discursive interest to CoPs as it illustrates that expert therapeutic truth claims are mutable and located in relational webs of power.

2.3.3 The medicalisation of MSD

Psychological explanations and treatments for MSD dominated the twentieth century until the 'Viagra revolution' of 1990s, in which MSD was radically constructed within a biomedical discourse. This discursive practice is of significance to CoPs as it distances MSD from the psychological interventions and knowledges they may draw on. This change was heralded by political and infrastructural pressure to maximise efficiency in health care systems that idealised 'magic bullet' solutions (Berry, 2013) for simple and complex health problems, and the patient's desire for a expedient, physically and emotionally non-invasive treatment (Tiefer, 2006).

Doctors had little to offer via medical interventions to men experiencing MSD up until the 1980s (Berry, 2013), but it was in 1982 at the International Society for Impotence Research that the cause of erectile dysfunction was claimed to be a problem of physiology. Within this medical gaze erectile dysfunction was objectified as a vascular obstruction as opposed to psychological accounts that located it in the mind (McLaren, 2009; Tiefer, 2006). The technological and pharmacological advancements in medicine and science provided increasingly sophisticated accounts of the physiological causes of sexual dysfunction, which Tiefer (2006) has referred to as the 'medicalisation of MSD' and influentially changed the treatment of men with this presenting problem.

Although there had been some pharmacological success in the 1980s to treat erectile dysfunction, it was not until the release of the first oral medication sildenafil citrate (Viagra), in 1998 that secured the dominance of the biomedical discourse of MSD. Over the twentieth century in the West taking a pill to remedy a medical issue had become a cultural norm, entrenched within medical discursive practices of treating disease and illness with medication (McLaren, 2007). MSD was now glossed as another symptom that could be treated by this means and with intelligent marketing of sildenafil citrate, MSD became reconstituted globally and by implication so did male sexual norms. Loe (2004) claims that it “changed our understanding of sex in America and, increasingly, is changing it around the world as well [...] Normal sex now means sex on demand, sex for everyone, and sex for life” (p.136).

The medicalisation of MSD reduces sex to a ‘mechanical process’ wherein erections are conceived in terms of ‘hydraulics’, and psychological and relational factors marginalised (Tiefer, 2006, 2012). The penis is able to move beyond its limitations with sildenafil citrate’s ability to produce an erection irrespective of contextual factors, on demand (or at least within an hour) and last longer than they would have otherwise. In this medical discourse the lack of erection is no longer seen as a symptom of a problem but becomes reified as the problem (Kleinplatz, 2004). As such, treatment may become focussed on restoring the penis’ ability to get erect rather than explore other possible causative factors e.g. relational or psychological issues.

The reinvigorated biomedical discourse of MSD perpetuates phallocentric and heterosexualist assumptions of sex, furthered by marketing techniques that emphasise the importance of sex within marriage and relationships, enforcing

normatively gendered expressions of sex and sexuality (Fishman & Mamo, 2001). Within advertising and marketing materials MSD was conveyed as a barrier to sex, as opposed to penetrative sexual intercourse, rendering sexual activities not involving a penis or penetration as insignificant (Kleinplatz, 2004).

In circulating a new norm of male sexuality the biomedical model of MSD perpetuated extant masculine discourses related to sexual performance (Fishman & Mamo 2001). Manliness, as indicated by virile sexual performances, became more demanding due to the use pharmacotherapies. Some men turned to Viagra to help meet these newly inflated cultural norms producing more frequent and longer lasting erections (McLaren, 2007) and escalating sexual insecurity in men (Tiefer, 1986).

The dominance of the medical construction of MSD has been attributed not only to the advancement in biomedical technologies and consumer demand but also the financial incentives of the pharmaceutical industry (Tiefer, 2006). In 1995 American men were recorded spending 600 to 800 million dollars annually on attempts to assure their sexual function (McLaren, 2007) and sildenafil citrate was recorded as the fastest selling pharmaceutical in history (Loe, 2004). Therefore the pharmaceutical industry has a vested interest in maintaining this medical gaze to MSD and other problems, and has assumed an influential role in governmental health business policies within the UK (Tiefer, 2006). Therefore a critical approach to the knowledges CoPs draw on and an interrogation of the wider power relations of who benefits or is disadvantaged by these particular understandings is crucial.

Managed care medical systems within the US also appear to contribute or enforce the biomedical production of sexual difficulties made apparent by sexupharmacology treatment being reimbursable through medical insurance, unlike psychological treatment for MSD (McLaren, 2007). This system thereby legitimises one causal explanation over the other, increases trade for medical doctors over psychological practitioners and constrains an individual's choices that are limited by finances. Similarly, in the UK due to the initial cost of patented sildenafil citrate to the NHS treatment was limited to specific causes of erectile dysfunction e.g. prostatectomy or underlying health issue (Department of Health, 2014). Here the role of institutions can be considered in the regulation of male sexuality by their classification of those that are deserving and those who are exempt.

The unidimensional treatment option contingent with the medicalisation of MSD has been criticised for being radically reductive (Tiefer, 2007). Despite acknowledgement that PDE5Is are effective in the short term there is little empirical effectiveness in long-term treatment (Berry, 2015) and high discontinuation rates by patients in the first three months of treatment leads Althof (2006) to suggest that sole attainment of an erection does not address potential relational or psychological issues. From this it could be argued that a more inclusive model of MSD is required to address all potential concerns that a monist psychological or biological account inherently neglect.

The 'biomedicalisation' of MSD remains a powerful discursive legacy in the understanding and regulation of male sexuality in contemporary society. This decidedly biomedical production of MSD contested the dominant psychological construct of this phenomenon and replaced it with an influential biomedical

understanding and treatment. From this potentially reductive medical perspective psychological practitioners, CoPs included, could be distance as expert helpers to men experiencing sexual dysfunction. In response to such criticisms and in order to embrace the multiple therapeutic perspectives and treatments available for MSD the adoption of the biopsychosocial model as been advocated by clinicians and researchers in the sex field (see section 2.3.5).

2.3.4 The DSM's diagnostic categorisation of MSD

As argued throughout this research language discursively constitutes MSD and its reality. By deploying the term 'MSD' in this research it is acknowledged that this privileges a particular version of this phenomenon with a distinct set of power relations and therefore needs to be interrogated. MSD is the dominant contemporary taxonomy of male sexual problems that continues to inform medical, psychological and psychotherapeutic disciplines' treatment of this phenomenon and reflects Western culture's preoccupation with diagnostic taxonomies. Currently there are two mainstream psychodiagnostic systems used to conceptualise mental health problems: The American Psychiatric Association's (APA) Diagnostic and Statistical Manual (DSM) and the World Health Organisation's International Classification of Diseases (ICD). For the purposes of this research I focus on the DSM as it is the most recently updated of the two and the ICD generally follows the DSM in its categorisations (Berry & Barker, 2015).

The creation of diagnostic classifications were an important way for psychiatry to enhance its scientific legitimacy by applying a medical model to human distress in the late 1800s (Cromby et al., 2003). Underlying assumptions of such a model aimed to categorise different clusters of symptoms and behaviours as reflecting distinct and differentiable pathologies and construct people in reductive binaries of

health/illness, normal/abnormal, and mad/sane. Modern diagnostic categorisations of mental health issues, such as the DSM and ICD, emerged in the post-war period with the development of international health organisations and have tended to maintain the assumptions of the disease model despite significant critique from mental health professionals and institutions. The BPS (2011) have argued for a dimensional approach to psychopathology arguing that cut-off points are arbitrary and question the validity and reliability of its diagnoses. In contrast a dimensional model of diagnosis constructs normal/healthy sexual functioning in degree, rather than in kind.

The DSM's objective claims of psychopathology and development through scientific inquiry has been contested by Kutchins & Kirk (1997) who illustrate how its classifications have been influenced by political and social forces. For example, original diagnostic categories were shaped by the psychoanalytic traditions which were dominant in psychiatry at the time. Male sexual problems first appeared in the DSM-III (APA, 1980) under the term 'psychosexual dysfunction' and relied on Masters & Johnson's (1966) account of MSD as an inhibition of the HSRC (see section 2.3.2). Under this umbrella term 'inhibited sexual desire, sexual excitement (impotence), delayed orgasm and premature ejaculation' are possible to diagnose. 'Psychosexual dysfunction' exemplifies the dominant psychological account of male sexual problems of the time, subjugating relational, social and biological accounts. It is in the DSM-III-R (APA, 1987) that the term 'sexual dysfunction' appears, and arguably reflects the recent discursive medical gaze of MSD as discussed in the previous section. Similar medical jargon was employed in renaming 'inhibited sexual desire' as 'hypoactive sexual desire disorder' and 'inhibition of sexual excitement/impotence' as 'erectile dysfunction'. This language change appears to discursively distance these issues from the traditional

psychoanalytic terminology by constructing them in biomedical and scientific terms.

The reliance on the HRSC (Masters & Johnson, 1970) was widely critiqued for its adherence to rigid and linear understandings of sexuality, for being genitally focussed on penis-in-vagina intercourse, emphasising treatment of the symptom rather than aetiology and providing a reductive one-size-fits all approach to therapeutic work (Kleinplatz, 2012). In addition, the DSM's categorisation of MSD was criticised for being difficult to operationalise. For example, premature ejaculation was defined as "persistent or recurrent ejaculation before, on, or shortly after penetration and before the person wishes it" (DSM IV-TR, APA, 2000; p. 552) and therefore reliant on the norms the assessing physician was subject to.

The latest edition, DSM-5 (APA, 2013) has responded to such criticisms with stricter criteria. For example, premature ejaculation is now defined as occurring within 60 seconds of the penis penetrating the vagina and before the individual wishes it. However, in this specific case heterosexual coitus is again privileged neglecting other sexual acts such as anal sex. However, the DSM-5 (2013) did acknowledge the problematic nature of the HSRC and subsequently removed it from its definition. However, all key categories continue to be tacitly related to desire, arousal and orgasm, illustrating the continuing discursive legacy of Masters and Johnson (1970).

There was considerable debate as to whether to include sexual addiction or hypersexual disorder within the DSM-5 (APA, 2013) (Ley, 2012) and the APA ruled against including the disorder. The surrounding discussions of this dysfunctional categorisation highlighted the moral and political contexts of the

invention of mental disorders. Ley (2012) argues the category lacks empirical evidence, is poorly defined, and too entrenched within moral and cultural imperatives to have any scientific reliability or validity. The debates over the inclusion of 'hypersexual disorder' highlights the discursive power games involved in objectifying a phenomena that may become constituted as a mental disorder and necessitating a critical approach to the classifications CoPs may resource their practice with.

The DSM and its defining criteria of MSD remain an influential diagnostic tool in Western culture in the fields of physical and mental healthcare providing a common language to communicate with clients and healthcare professionals, and give a framework that may assist clinicians in conceptualising sexual problems (Berry, 2014). However implicit in its discursive practice are normative assumptions about sexual behaviours, pathology and aetiology. A critical perspective to diagnostic tools that CoPs may implement or be guided by in their work with MSD is therefore vital.

2.3.5 The biopsychosocial model of MSD

As illustrated above, during most of the twentieth century treatment for MSD was psychologically orientated but biological and social accounts gained cultural value in the last quarter of the century (Waldinger, 2008). Acknowledgement of the limitation of reductive monist accounts gained prominence in general healthcare in the 1960s and a commitment to holism by neurologist and psychiatrist, Grinker (1964), saw the development of the inclusive biopsychosocial model. This model gained value from conflicts between biological reductionism and psychoanalytic orthodoxy (Frankel, Quill & McDaniel, 2003) and has subsequently become a

pervasive contemporary standard in healthcare and the health sciences (McCarthy & McDonald, 2009).

Biopsychosocial treatment models emphasises sexuality as:

“multi- causal, multi-dimensional, complex phenomenon requiring assessment and targeted treatment interventions for the man, woman and couple [...] The assumption is that, at the core, sexuality is a psychological, interpersonal process rather than a biological, individual process” (McCarthy and McDonald, 2009: p31).

Discursively, the biopsychosocial model glosses sexuality as a ‘complex phenomenon’ and appears to be inclusive by encompassing extant circulating constructions of MSD, thereby minimising the limitations of reductionist accounts indicative of previous eras. The biopsychosocial model is argued to be diagnostically and therapeutically holistic attending to overlap and interaction between each domain in the model promoting an understanding that they are not discrete elements. Implicit in this interactional model is the assumption that regardless of the aetiology of MSD there may be a psychological, behavioural and physiological outcome, and therefore all need to be considered. A biopsychosocial understanding expands beyond the dichotomisation of previous models based upon the dualistic understandings of the mind/body binary and the treatment choice of psychotherapy or pharmacotherapy respectively.

By recognising MSD as multiply constructed and treated, the practitioners deploying the biopsychosocial model are implicitly required to negotiate and travel across several paradigms, as done by CoPs. For example, adherence to the model means having adequate knowledge to assess the possible biological, relational and psychological factors of the presenting issue. Due to the

disciplinary division of specialities between physical health and mental health there may be barriers to psychological and psychotherapeutic practitioners treating MSD. For example, assessment of biological factors may be problematic for mental health professionals without medical training or access to medical screening facilities. Therefore, it is likely that clinicians who are subject to particular accounts of MSD may privilege a specific discursive perspective, leading Gil and Hough (2007) to criticise the model as tokenistic.

Further research, by McCarthy and McDonald (2009) support Gil and Hough's (2007) claims that for MSD the biopsychosocial model may be inadequate due to the different dominant discursive resources privileged by physical health and mental health practitioners. In their study of interventions recommended by primary care practitioners to treat MSD, they reported medication was the first line of treatment with limited assessment of relational factors (meeting with partner of patient) and neglect of psychosocial constructions (attitudes towards sexuality). Therefore, practitioners, CoPs included, may benefit from a reflexive gaze to the knowledges they may privilege and exclude. Additionally, McCarthy and McDonald (2009) draw attention to the effect of the healthcare context in which these assessments took place e.g. limited time to assess patients and the capacity to prescribe medication.

The construction of the holistic biopsychosocial model of MSD in context of the traditional disciplinary separation of the medical from the psychological profession demands greater integration or multidisciplinary team working. This may have practice implications for CoPs and other mental health practitioners when confronted with MSD. They may need to ensure adequate assessment and

treatment of biomedical accounts of MSD and be aware of how the context they are working within may influence their therapeutic practice.

Implicit in the biopsychosocial model is the continued prioritisation of the biological account of MSD, which has led Metz and McCarthy (2007) and Cromby et al. (2013) to argue for a psychobiosocial model to prioritise the psychological discourse in this holistic model. Although the biopsychosocial model is considered as the holistic contemporary conceptualisation of MSD critics have argued it to lack pragmatic standardisation. However, this could be argued to reify new models which will inherently limit or prohibit alternative perspectives.

The biopsychosocial model is relevant for CoPs because it advocates a holistic perspective that spans across disciplinary knowledges that construct MSD, highlighting that professionals and contexts may shape what is privileged or masked. As CoPs are integrative/pluralistic they may lack biomedical understandings of MSD and if deploying this model may need to draw on other forms of 'expertise' in service of their client.

2.3.6 Critically informed psychological perspectives of MSD

The turn to language, Foucault's contributions to the field of sexuality, and feminist critique has been associated with the emergence of a variety of critical perspectives towards mainstream knowledges and treatments of sex and its problems (Kleinplatz, 2012). A constructionist approach to MSD and wider discourses of sex and masculinity have provided important techniques for sexologists, researchers and clinicians to critique, contest and provide alternative theories and therapeutic approaches to dominant expert biological and psychological constructs. These contemporary critical approaches are worth

examining due to their shared epistemological concerns with this research, highlighting the potential innovative and productive power a critically discursive perspective can offer (Gergen, 2009).

The acknowledgement of the importance of social context from the 1970s to now have arguably seen a proliferation of discourses about sexual behaviours, sexual scripts, gender and masculine identities in academic and lay populations in Western culture. Sex and its facets have remained a preoccupation of Western society and reflected by its eminence in media, advertising, and the news. Although reflexive critical approaches to categories of sexual health, wellbeing, gender and sexual behaviour have problematised these reductive and rigid norms and offered alternatives, prevailing norms of masculinity and sexual function continue to dominate the vernacular. However, critical sexologists, therapists, and psychologists continue to promote a meta-gaze to the assumptions underpinning mainstream expert knowledges.

Gagnon and Simon (1973) are credited by Atwood and Klucinec (2008) for leading the way for social constructionism in the field of sex therapy by privileging the social interpretation of behaviour. Their introduction of 'sexual scripts', embedded in the symbolic interactionism of the Chicago School, located an individual's sexual behaviours as a product of a dialectic of cultural symbolic systems, an individual's fantasy life and social interactional norms. Similarly, engaging the social nature of problem accounts in therapy led Epston and White (1990) to develop narrative therapy. Drawing on the ideas of Foucault, these clinicians located all sexual meanings and behaviours as determined by the individual's socio-cultural context. The prioritisation of linguistic meaning making reconstructed the individuals' sexual dysfunction as 'stories' about their sexual

selves, in which values and problems could be experienced and interrogated. Through the power of rhetoric the narrative therapist facilitates the adoption of a more empowering story. However, debate continues over the ability of the therapist to negotiate the influential role of therapist without claiming an oppressive expert position in the therapeutic encounter.

Clinicians utilising the social constructionist perspective have questioned the assumptions of male sexuality inherent in mainstream approaches to MSD and offered alternatives to the 'performance-based model' (Berry & Barker, 2015). The aspects of intimacy and pleasure that appear minimised or evacuated from traditional conceptions of treatment of MSD are now prioritised in Metz and McCarthy's (2012) 'Good Enough Sex Model' and in Kleinplatz et al.'s (2009) 'Optimal Sex Model'. The models construct MSD as a complex problem that is grounded in the comprehensive biopsychosocial approach and prize the subjective meaning-making process of the individual or couple. Sexual performance is decentred and flexibility and variability are embraced. However, caution may need to be exercised by practitioners exercising these new directions and different models with men presenting with MSD. It is suggested that male clients need to be invited to identify, and perhaps deconstruct prevailing sexual and gendered discourses in the world, rather than being subjugated by the critical practitioners' expert knowledges. Viewing MSD, as well as other sexual problems, as social products has led Kleinplatz (2012) and Tiefer (2004) to advocate for their profession to engage with and promote wider societal change beyond the confines of individual therapy.

Within increasing multiple perspectives to the treatment of MSD, a CoP may be confronted with more therapeutic knowledges and practices, which could be

overwhelming or liberating. This raises important questions as to how CoPs who practice integratively, pluralistically or relationally manage these diverse and competing therapeutic truth claims. McLeod and Cooper (2010) advise open collaboration with the client to inform the choice of therapeutic intervention and empower the client in the inherently unequal power-laden relationship. However, it could be argued that this may be experienced as overwhelming to the client who may be seeking guidance and expertise.

2.3.7 The reification of sex therapy

The objectification of sex and its problems as a 'specialist' or 'expert' field of knowledge and the reification of 'sex therapy' and 'sex therapists' is important to consider in relation to the treatment of MSD and how CoPs may be positioned in relation to this discipline and its specialist practitioners.

The term 'sex therapy' was first established by Masters & Johnson (1970), which emphasised the direct treatment of sexual dysfunctions using time-limited interventions, behavioural homework techniques and couple communication training to reduce performance anxiety and restore the 'natural' sexual response in contrast to the dominant psychoanalytic paradigm of the time. Within 15 years it had gained considerable growth, become widely accepted by public and professionals as a specialised type of therapy, a brand name in the Western world (Kleinplatz, 2006) and self-regulated by its own training institutes (McLaren, 2007).

Binik & Meana (2009) argue that "the perception of distinctiveness emerged because sex therapy conveniently filled an important yet empty niche for public and professionals" (p. 1017) indicating a societal discomfort with issues of sexuality in both domains. Such specialisation may tacitly contribute to the

perpetuation of this 'othering' of sex and its problems, and contribute to distancing it from other mental health problems. This may encourage other health professionals, CoPs included, to immediately refer to a sex therapist when presented with a client with MSD. With regard to this issue CoPs may be subjugated in a power hierarchy to sex specialists, becoming subject to and produced by a discourse of 'incompetent generalist' when approached by this particular issue.

Although specialisation may produce a discourse of 'expertise' and legitimate claims to the MSD population, from a discursive perspective this may promote a myopic view of the individual and their issues. MSD may become an isolated issue in the client's life distinct from other relational or psychological understandings (Binik & Meana, 2009). Contemporary sex therapy practice draws on the inclusive biopsychosocial perspective (see section 2.3.5) so as to avoid limited singular perspective of MSD. However, the adoption of the biopsychosocial model across other physical and mental health domains is also prevalent making sex therapy indistinct in this respect. A reason why Binik and Meana (2009) suggest that sex therapy need not be a specialist discipline. It may be argued that CoPs' positioning between and in multiple and diverse therapeutic knowledges means they are well located to deploy the biopsychosocial model to treat MSD.

The reification of the speciality of sex therapy may also contribute to professional ghettoization where generalist psychotherapy trainings neglect sexual issues and MSD. This discursively distances this problem account from generalist CoPs and positions these specialist professionals as better equipped and skilled in this domain. This is in opposition to Binik and Meana (2009) who argue that

contemporary sex therapy is not methodologically distinct from generalist therapeutic practice and the diversification of therapy approaches in the field does not sufficiently warrant sex therapy its privileged status. This distancing may also disadvantage the specialists in an estrangement from developments in generalist psychotherapy and psychology, for example the emphasis on the importance of the therapeutic relationship (Clarkson, 2003).

From a discursive perspective sex therapy, like other therapies, is viewed as a cultural practice and may continue to perpetuate traditional assumptions of sexuality and sexual function that it was founded on (see section 2.3.2) (Berry & Barker, 2015). This 'specialist' profession appears to position its self in a power hierarchy to generalist therapists but has not gone uncontested. Specialism may denote expertise but it may also produce tunnel vision and isolate itself from wider concerns of therapy. Therefore, it is important for CoPs to take a critical perspective to this discipline to become aware of the power relations and positioning they may be located in with respect to this specialism and the implications it may have in their work with MSD.

2.4 Summary of Chapter Two

In summary, this chapter has traced the emergence of MSD in Western culture through out history, illustrating it to be mutable, power-laden, and multiply constructed. These changing and heterogeneous therapeutic constructions have highlighted their reliance on, and in some cases resistance to, the norms governing male sexuality, identity, behaviours and the body's sexual function. Therapeutic accounts of MSD have ranged from the divine, biogenic, psychogenic and sociogenic and have been illustrated to be socio-historically contingent. Implicated in these constructions are the positioning of an array of 'experts' across

disciplines as legitimate helpers for this presenting condition. MSD in the twenty-first century appears to remain a poly-discursive site offering CoPs diverse heterogenous accounts to draw on in their work with this problem. This genealogy has provided a macro-level overview of some of the discursive resources available to CoPs and it is therefore imperative to now provide a local level analysis of power relations. This is achieved by interrogating CoPs' talk about their work with MSD. How this has been conducted in this research is now discussed in the next chapter.

Chapter Three

Methodology and Method

3.1 Introduction to Chapter Three

In this chapter I outline the post-structuralist methodology and detail the method I used to address the research question: *“What are the discursive power relations in counselling psychologists’ therapeutic accounts of working with male sexual dysfunction?”*. Firstly, I locate the Foucauldian Discourse Analysis (FDA) adopted in this research (as discussed in Chapter One) and its epistemology in the discipline of psychology, and then specifically in the field of counselling psychology. Secondly, I outline the method employed to ethically collect and analyse the data. Lastly, I discuss my researcher reflexivity and the criteria of quality that evaluates this applied qualitative research method.

3.2 Foucauldian discourse analysis and a post-structuralist epistemology

As described in Chapter One, a post-structuralist approach to knowledge posits that all meaning is socially constructed and historically located (Gergen, 1985, 2009). For this reason, language, as the medium of transmitting and generating knowledge, is the focus of this research. From this social constructionist perspective, language is argued to be productive rather than descriptive, and thereby opaque, strategic and power-laden. Therefore, this research aims to make visible some of the contingent power relations in the therapeutic accounts of 10 volunteer CoPs in their talk about working with MSD.

In contemporary psychology, FDA and discursive psychology (DP) are the two most popular approaches for examining the constructive role of language in

qualitative work (Willig, 2013). To clarify the Foucauldian methodology and its epistemology it is useful to compare it with DP's conception of language and its relationship to its speakers. Although Parker (1992) and Willig (2013) highlight the distinctions between the two, they share many common assumptions, as argued by Potter and Wetherell (1995), whilst Wetherell (1998) goes further suggesting a synthesis of the two.

Wetherell (1998) describes the focal difference between the two discursive methods by their 'top-down' or 'bottom-up' perspectives on the use of language. She argues that DP is a 'bottom-up approach', which concerns itself with the micro processes of talk and perceives individuals as skilled and agentic users of language. Individuals are thought to deploy language to manage their interests and bring about effects. Wetherell (1998) calls the emphasis on what participants are 'doing with their talk' action orientation and is the particular focus of this 'bottom-up' approach. This is illustrated in Tucker's (2004) study, which examines the rhetorical work of people experiencing chronic fatigue syndrome and how they use language to manage issues of blame and personal accountability in their problem accounts.

In contrast to discursive psychology, an FDA approach attends to the macro processes of discourse, and is thereby considered to have a 'top-down' perspective. This method prioritises the constitutive power of language, which is understood as discourse, and examines the wider socio-political influences and various social apparatuses through which power is exercised and individuals made subjects. As such, FDA was initially used within psychology in the late 1970s as a critical response to mainstream psychological knowledge's emphasis on individualism and the social regulative effects of their practice (Arribas-Ayllon &

Walkerdine, 2008; Henriques, Holloway, Urwin, Venn, and Walkerdine, 1984). FDA informed research has critiqued psychological knowledge and its institutions (Parker, 1999; Rose, 1985), and the social interaction of therapeutic encounters (Guilfoyle, 2001; Hodges, 2002).

Considering the research question above and the analytic interests of this proposed research, an FDA is argued to be most appropriate methodology due to its explicit concern with top-down discursive power relations that highlight how participants are talked by the language they use, the discourses that resource their accounts and the positions made available or unavailable. Therefore the epistemological assumptions of this research are guided by a radical post-structuralist perspective that does not go beyond the confines of the discursive power of talk (Edwards, Ashmore & Potter, 1995).

Foucault did not detail or prescribe a method for conducting an FDA in his archaeological and genealogical work, as this was counter to his post-structuralist stance that eschews formalisation. Likewise, Foucauldian informed researchers have been reluctant to detail a method and each study is treated as topic specific. In spite of the impossibility of standardisation, psychological researchers have provided general guidelines to aid the conducting of an FDA (Arribas-Ayllon & Walkerdine, 2008; Hook, 2007; Parker, 1992), which were found useful in the completion of this research.

Arribas-Ayllon and Walkerdine (2008), outline three broad dimensions of FDA that are of importance to psychologists. Firstly, they argue the importance of including a historical perspective to the analysis of discursive practices, which I have done in Chapter Two's genealogy of MSD. Secondly, an FDA is concerned with the

operation and mechanisms of power between objects and subjects. This analytic focus is addressed in the review of relevant literatures and in the analysis presented in Chapter Four. The final dimension of analysis is concerned with how individuals are made subjects and the discursive practices through which they are positioned (subjectification), which is the principle focus of the analysis presented in Chapter Four.

In addition to the FDA guidance provided by these psychological researchers (Arribas-Ayllon & Walkerdine, 2008; Parker, 1992; Willig, 2013) they alerted my attention to the importance of interrogating my own discursive positioning as a CoP researcher of MSD. As such, the acknowledgement of the interpretative process of an FDA and the inherent influence of my subjectivity on the reading of the data is addressed in section 3.4 (Finlay & Gough, 2003).

3.3 Methodological design

CoPs' accounts of working therapeutically with MSD were elicited through semi-structured interviews volunteered by 10 participants from an opportunity sample. Semi-structured interviews are a common and pragmatic way of collecting relevant text for analysis (Arribas-Ayllon & Walkerdine, 2008; Willig, 2013) and as Parker (1992) argues an FDA may be carried out "wherever there is meaning" (p.1). Foucauldian informed research (e.g. Benford & Gough, 2006) has employed similar data collection and analytic methods demonstrating this sufficient to collect rich enough data.

3.3.1 Ethics

The research was granted ethical approval by the University of Roehampton's Ethics Committee. To ensure the research was conducted as ethically as possible

the British Psychological Society's (BPS) Code of Ethics and Conduct (BPS, 2010) and the Division of Counselling Psychology's Professional Practice Guidelines (BPS, 2001) were drawn upon and adhered to. Confidentiality and anonymity of participants was assured throughout the research by assigning pseudonyms. All information that could identify participants was omitted during transcription. Audio-recordings and transcripts have been stored according to data protection law, and files will be destroyed after 10 years, in accordance with BPS ethics (BPS, 2010). Participants were required to sign an informed consent form (see Appendix 3), which notified them of their rights, including confidentiality and their freedom to withdraw from the research if they chose. At the conclusion of the interview, participants were given a debrief form (see Appendix 5) to ensure the ethical conduct of the interview. The form provided the researcher's contact information, as well as the contact details of professional organisations' that could be approached for support should the participants' experience any distress after the interview. No participants reported concern or withdrew from the research.

3.3.2 Participants

Ten participants were recruited for this research via advertisement and word of mouth. The research advertisements targeted CoPs via emails gathered from online counselling directories and advertisement on the electronic newsletter of the Division of Counselling Psychology (see Appendix 1a and 1b). For an FDA large participant samples are not required as this qualitative methodology seeks to interrogate the discursive resources mobilised and their contingent power games in participants' accounts, and does not seek to represent or generalise beyond the sample (Willig, 2013). A modest participant sample was therefore required to provide sufficiently rich data to identify some of the discursive constructions deployed within the accounts of CoPs. Sample sizes of 10 participants have been

shown to be sufficient for the purposes of such a Foucauldian inspired approach (e.g. Randol, 2014).

The inclusion criteria specified that all participants had to be a trainee or qualified CoP and had experienced working therapeutically with at least one client with MSD. This specification ensured that participants would have experience to draw on to facilitate discussion relevant to the aims of this research. No additional criteria was stipulated by the researcher as this methodology values all contributions, and contests the essentialisms associated with social constructs such as gender, years of experience and work setting. However, demographic information was collected confidentially from all participants in case it was required to offer a context to the transcription extracts used in the analysis. This information is summarised in Table One below and the implications of this opportunistic sample are discussed in Chapter Five (see section 5.3.2.)

3.3.3 Data collection

On initial contact from potential participants further information explaining the study and the expectations of participation were issued (see Appendix 2). This outlined the premise of the study, requirement of a recorded interview lasting approximately 60 to 90 minutes, and the inclusion of a debrief. A date and time was agreed to conduct the interview at a convenient location. In most instances this was the participant's home or place of work. All interviews were carried out in a private space where participants could speak free from interruption.

On meeting participants the information sheet was again given (see Appendix 2) and participants encouraged to raise any concerns or questions. Participants signed a consent form declaring they had agreed to take part, were aware of their

right to withdraw from the study and had understood the limitations of the agreed confidentiality (see Appendix 3). Participants were issued with a unique identifier to ensure anonymity and confidentiality. Interviews were recorded using a Sony ICD-PX820 digital voice recorder.

I was guided by the following five open questions at interview (see Appendix 4):

1. Could you tell me about your experience of working with male sexual dysfunction?
2. What do you think about the presenting problem of male sexual dysfunction?
3. What do you think has informed your practice whilst working with male sexual dysfunction?
4. Is there anything else you would like to talk about or mention with regards to male sexual dysfunction?

These questions were used to gain access to the participants' truth claims about their therapeutic work with MSD. The research questions were used as a guide and I was flexible in my approach to facilitate questions, clarify answers, and engage the participants (Willig, 2013).

After the interview the participant was provided with a debrief sheet (see Appendix 5) and an opportunity to ask questions and feedback about their experience of the interview.

The interviews were then transcribed in accordance to Malson's (1998) transcription conventions (see page 7). This transcription style was appropriate as FDA research is concerned with content and use of language, rather than the speech's delivery such as intonation or speed.

Table One: Summary of participant demographics

Gender Female (F) / Male (M)	Nationality	Qualified (Q) or Trainee (T)	Theoretical orientation	Additional / Specialist Training in Sexual Issues? Yes (Y) / No (N)	Therapeutic Setting
M	White British	T	Integrative / pluralist	N	Third sector – HIV service & NHS Primary Care
F	White British	T	CBT / Systemic / Integrative	Y	Private practice - relationship & sex therapist / third sector general counselling
F	Black Caribbean	T	Integrative	Y	NHS addiction service & NHS sexual health service
F	White European	T	CBT/ Integrative	N	NHS primary care & private practice
M	White European	Q	Psychodynamic / Integrative	Y	Private practice / NHS & Third sector sexual health
F	White European	T	Existential/ Phenomenological	N	NHS Primary care & private practice
M	White European	Q	Integrative	Y	Third sector relationship & sex therapy, & private practice
F	White European	Q	Existential/ Phenomenological	Y	Private & third sector HIV service
F	White European	Q	Existential/ Phenomenological	Y	NHS sexual health & psychology service
F	White British	Q	Psychoanalytic / Integrative	N	NHS primary care

3.3.4 The analytic steps applied

The discursive practices and contingent power games in these 10 participants' therapeutic accounts of working with MSD was the central analytic interest of this research. The analysis was informed by Willig's (2013) six stages to scaffold the analytic process, and supplemented by drawing on Parker's (1992), and Arribas-Ayllon and Walkerdine's (2008) writings to sharpen the analytic gaze.

Firstly, the analytic process required immersion in the data. This was achieved by reading through each transcript several times, familiarising myself with the themes and content related to the research question. Initially, I focused on how MSD was discursively objectified in different ways and what frames of intelligibility allowed this understanding, for example what norms resourced their understanding of male sexuality, function and dysfunction. Consistently I held in mind how these participants were being 'talked' by the discourses populating their accounts and the contingent power relations of these understandings. Secondly, I interrogated what subject positions appeared to be made available or prohibited by the networks of meaning producing the particular therapeutic accounts of MSD. Here I attended to the discursive power of these locales, what was afforded and closed off by these positions and the power dynamics of the relations to other professionals, disciplines and clients. Lastly, and although the most tentative of the analytic steps, I examined the ways in which certain subject positions appeared to be associated with ways of being for these participants, as this seemed particularly apparent in how these participants expressed their sense of clinical competence in working with MSD.

During the analysis of these 10 CoP participants' accounts of working with MSD it became visible that this presenting problem was constituted in diverse and heterogeneous ways. The analysis unmasked wider power relations in norms regulating male sexual behaviour, as well as local power relations illustrated by nuanced subjectivities. These two analytic interests are argued to address the research's concerns and presented in Chapter Four with illustrative extracts.

This post-structuralist approach acknowledges that the analysis presented in Chapter Four is a product of the researcher and participants being subject to and acting within networks of cultural meaning (Willig, 2013). Qualitative research advocates the inclusion of researcher reflexivity to acknowledge and make visible the interpretative nature of research and the possible implications of the researcher in the research process (Finlay & Gough, 2003). I now explore reflexive issues related to this research and provide reflexive notes to contextualise myself within this research.

3.4 Researcher's reflexivity

Addressing researcher reflexivity has become a standard practice and distinguishing feature of qualitative methodologies, that arguably enriches the quality of analysis (Gough, 2003). Incorporating reflexive practice as part of the methodology explicitly acknowledges and examines the active role of the researcher in the production of knowledge in the investigative process. Although reflexivity is often referred to as a homogenous practice, Finlay and Gough (2003) have highlighted its multiple constructions, diverse use and subsequently articulated the case for 'reflexivities'. This section examines the role of researcher reflexivity in an FDA and specifically in this research.

A discursive post-structuralist approach to reflexivity questions the utility of personal reflexivity that is commonly employed to make the researcher's effects on the research process visible (Finlay & Gough, 2003). Personal researcher reflexivity aims to discover and make explicit the researcher's 'real' motivations or hidden agendas. However, this form of reflexivity is reminiscent of the discourse of positivism (Gough, 2003), in that it implies an objective and stable self that can be known 'better' by personal reflection, allowing a more 'truthful' account. The social constructionist perspective applied in this research opposes this realist account, understanding the self to be constituted as decentred, relational and incomplete (Gergen, 2009). Therefore, it is impossible to untangle the researcher from the researched, as they are inextricably embedded in its creation. Hence, a post-structuralist reflexivity emphasises locating the researcher within prevailing discourses relevant to the enquiry (Harper, 2003) and yields claims to researcher transparency impossible.

The process of reflexivity is argued by Foucault (1984/1991, 1985/1992) in later work as a questioning or critique of the self, which could contribute to resistance practices in self-formation. He argues, this reflexivity could allow individuals to resist the norms they are constituted by and offer alternative ways of being. Applying this reflexive perspective to this research requires me, as the CoP researcher to inspect the discursive resources and positions I may mobilise and the power games I may be unknowingly subject to. However, as Butler (2001/2004) argues, an individual's reflexivity is always constrained by the frames of intelligibility the individual is constituted by, and therefore total reflexivity can never be assumed or an end point reached. Therefore, my researcher reflexivity is offered to provide a context in which this research was produced, followed by the application of a critique to the practice of reflexivity itself.

Firstly, this research was initiated from my employment in a private health care service specialising in prostate cancer. I became aware of the diverse and oppositional accounts of MSD in the talk of experts (urologists, GP specialists, sex therapists, nurses) staffing the service and the apparent dominance of the biomedical construction of MSD. Psychological discourses appeared marginalised, as MSD was conceptualised in seemingly reductionist functional terms. I became curious as to how and why relational and psychological understandings of MSD seemed to be neglected in this context, and the implications this appeared to have for treatment options made available to patients.

Secondly, as a CoP trainee and from my therapeutic work I became increasingly sensitive to the language clients and myself used when discussing issues of sex. This area seemed to be complex and discursively power-laden with apparent influential effects for individuals' sexual lives, behaviours and subjectivity. In my work with clients presenting with MSD I became interested in the competing explanatory constructions of MSD and the diverse ways of treating the issue. This issue seemed problematic in the competing and interactive perspectives ranging from the social, psychological and biological spheres. It became evident, as Foucault (1978/1998) argues, that sex is a powerful and complex discursive nexus. As a practitioner, I began to interrogate the competing truth claims of the diverse expert knowledges that resourced my therapeutic understanding and choices. I wondered what understandings and ways of being these discourses may have limited and prohibited, and what power games fellow CoPs may also find themselves located in.

Thirdly, through working with men experiencing sexual difficulties as a trainee CoP, I began to reflect on the broader power relations exerted in the construction of professional therapeutic disciplines. The constitution of 'sex therapy' as a designated specialist profession seemed to raise issues of authority, expertise and competency in working with clients experiencing MSD. I was intrigued by the discourses CoPs may mobilise in their accounts of MSD with respect to these different professional disciplines, and the subject positions they afforded.

To maintain the post-structuralist critical gaze that informs this research I will now comment on reflexivity as a professional practice in CoP. Reflexivity has continued to gain significance in professional psychotherapeutic discourses post modernity (Downing, 2004) and is argued to help negotiate the multiple therapeutic and epistemological perspectives inherent in counselling psychology (Strawbridge & Woolfe, 2010). As such practitioner reflexivity has been instated as a professional competency for CoPs (BPS, 2001) and a requirement for CoP training. Reflexivity could be argued to be a 'confessionary' or surveillance practice (Foucault, 1977/1980) by which individuals come to know and regulate themselves towards cultural norms, standards and practices. Therefore, the promotion, importance and value of reflexivity as a standard practice must also not be beyond critique or contestation as it too is situated within a web of power relations. Further critique of my reflexive practice is presented in Chapter Five of this research (see section 5.3.3).

3.5 Criteria for quality in qualitative research

The indicators of quality in quantitative research, such as reliability and validity, are not appropriate for post-structuralist inquiries (Willig, 2013). An FDA is

concerned with interrogating relations of power of discourse and acknowledges the multiplicity of 'truth'. This methodology assumes no objectivity between the object of study and the researcher (Parker, 1992) and interpretation is considered inevitable as all knowledge is socially and historically embedded and co-created. This non-realist perspective therefore considers searching for the 'truth' irrelevant. However, Yardley (2000) does provide guidance to increase the trustworthiness of qualitative research, which is now addressed.

Yardley's (2000) markers of quality are concerned with issues of sensitivity to context, coherence, transparency and reflexivity. As argued throughout this research an FDA always locates knowledge and power within a specific socio-historical context. This has been achieved in Chapter Two by tracing the diverse constitutions of MSD and their conditions of emergence. Within Chapter Four the analysis offered is acknowledged as one of many readings possible and as a product of the specific interaction between researcher and these participants. This demonstrates a coherence of the post-structural perspective maintained throughout the research. Transparency has been achieved within this chapter by detailing the method and analytic steps applied to data gathering and analysis. Lastly, reflexivity in relation to carrying out post-structuralist research has been considered in this chapter, and reflexive commentary provided in this chapter and Chapter Five (see Section 5.3.3) to provide a context for my discursive positioning.

Morrow (2005) argues that postmodern and critical research's quality should also be evaluated on how issues of political and social change are made. This has not been the explicit aim of this research. Rather, this research has sought to draw attention of CoPs to the power games they may be located within regarding therapeutic work with MSD. No claims to change can be offered beyond aiming to

raise awareness of CoPs to the power of their talk to this problem account. In Chapter Four I present the analysis produced from the applied methodology and method detailed in this chapter.

Chapter Four

Analysis

4.1 Introduction to Chapter Four

This chapter presents the analytic findings from the accounts contributed by ten CoPs about their therapeutic work with MSD. The analysis highlights two key discursive aspects addressing the research question: “*What are the discursive power games in counselling psychologists’ accounts of working therapeutically with male sexual dysfunction?*” Firstly, wider contextual discursive norms are identified in these CoPs’ therapeutic talk that seem to regulate male sexuality within circulating discourses of masculinity. Secondly, three distinct discursive therapeutic subject positions are identified as talked by these participants. These nuanced subjectivities are named ‘the Sexpert’, ‘the Amateur’ and ‘the Critical Practitioner’. Overall these results make visible examples of both the macro and micro power relations in the talk of these 10 CoPs and Table One provides a summary of the analysis presented in this chapter.

As addressed in Chapter Three, the reader is reminded that this analysis is one of many possible readings of the data and does not claim to be exhaustive, but a privileged selection of discursive interests (Harper, 2013; Parker, 1992). Furthermore, analytic commentary is confined to highlighting discursive resources and contingent power relations, without making any claims to material reality (Edwards, Ashmore & Potter, 1995).

Table 2. Summary of presented analysis

Summary of the contextual norms and the three therapeutic subject positions illustrated in this analysis.

4.2 MSD within wider contextual norms of masculinity	
<p>4.2.1 Cultural expectations of male sexual performance</p> <p>4.2.2 Cultural expectations of masculinity</p>	
4.3 Therapeutic subject positions	Illustrative Discourses
4.4 The Sexpert	<p>4.4.1 The exclusivity of the Sexpert</p> <p>4.4.2 The objectification of MSD in diverse knowledges</p> <ul style="list-style-type: none"> • MSD only understood in relationship • MSD as caused by performance anxiety • MSD understood in psychodynamic processes
4.5 The Amateur	<p>4.5.1 MSD objectified as ‘complex and other’</p> <p>4.5.2 Am I equipped?</p> <p>4.5.3 Deference to the specialist</p>
4.6 The Critical Practitioner	<p>4.6.1 Meta-perspectives for knowledges</p> <p>4.6.2 Exercising critical practice</p> <p>4.6.3 Reflecting on limits of knowledge</p>

4.2 MSD within wider contextual norms of masculinity

Since the linguistic turn in psychology, gendered discourses in Western society have been explored to see how ‘maleness’ is performed in daily life (e.g. work, family, relationships) and their power effects of these related constructions (Butler, 1999). These wider contextual norms are important as they provide a context of intelligibility for the specific problem of MSD and were significant enough that every CoP participant drew on these cultural resources in their therapeutic accounts of this presenting issue. Specifically, these CoPs talked about the socio-cultural norms they perceived to govern male sexuality and that their male clients presenting with MSD were subject to. Even though these imperatives were glossed by these CoPs as mythic, the cultural expectations identified were constructed as influential pressures regulating male sexual performance and masculinity, and therefore important to interrogate as discursive resources that have been historically inherited, as introduced in Chapter Two.

4.2.1 Cultural expectations of male sexual performance

During each interview, every participant discussed their male clients experiencing MSD as subject to idealised cultural pressures governing sexual performance, for example:

Extract 1

...it should be a foot long, hard as steel, you know, er, once it's up it's up, it shouldn't need any touching [...] no body should need to touch it. It should just be erect when you need it to be and it should stay erect until you want it to go down. (Sarah, L305-310)

Extract 2

...men should be able to have an erection any place, any time, i-i-in any emotional state, um, whether there has been a natural disaster or not. (Pascal, L66-68)

Extract 3

...there is this myth of 100 percent, um, sexual performance throughout your life when, well it is a myth! (Celeste, L307-309)

In these discourses erectile ability is prioritised and portrayed as the defining criterion of male sexual performance and seems to be conflated with sexual functioning. This idealised cultural norm also appears reductively binary in the categories of success/failure and sexual function/dysfunction. The penis is produced as a disembodied or inorganic 'tool', distanced from relational or psychological discourses, as Sarah illustrates in drawing on the circulating expectations on a man's erection: *"it should be a foot long, hard as steel"*. The disembodied nature of the erection is re-emphasised when she states *"[the penis] should be erect when you need it to be"* locating it within a discourse of rational control. This is echoed in Pascal's comment that *"men should be able to have an erection any place, any time, i-i-in any emotional sate"*. Reifying the penis in this way seems to exclude any implication of relational or psychological factors in sexual performance. This 'all or nothing' phallocentric construction by implication seems to pathologise any variation other than *"100 percent, um, sexual performance throughout your life"*.

Considering these accounts from a cultural historical perspective, it is interesting that these crude constructions still have currency within which MSD is located and

pathologised. As noted in Chapter Two, this vernacular discourse appears to have been maintained in contemporary society by the medicalisation of erectile dysfunction and its emphasis on unfailing erections (Tiefer, 2006). Contemporary psychologists have also acknowledged this conflation of performance as normative and regulatory, for example Flowers, Landridge and Gough (2013).

4.2.2 Cultural expectations of masculinity

By contrast to overt sexual performance discourses illustrated above, participants also talked about masculinity as an interior gendered identity. This was achieved by reference to personal identification with this exaggerated sexual function noted above.

Extract 4

... to a man it's [the penis] the symbol of, um, that is, you know, says everything about them. (hm) How it [the penis] works says everything about them (Sarah, L320-324)

Extract 5

...they might see it as acknowledging weakness. You know you're not that perception that you [the client] had of yourself, this ultra strong man that can conquer any problem. (Celeste, L540-543)

Extract 6

...it's a sign of, um, weakness. It's a sign of, it's, um, it's, um, a, what's the word; it's an infringement on their masculinity. (Charlotte, L267-269)

Gendered identity or what it means to be a man is produced as his sexual function, noted by Sarah *“how it [the penis] works says everything about them”*. This reductive *“sign”* or *“symbol”* according to this norm seems to essentialise masculine identity. Within this sexual performing discourse one is either the *“ultra strong man that can conquer any problem”* or by inference is ‘weak’. This resonates with Foucault’s (1978/1998) argument that sexuality and sexual behaviour have come to speak the ‘truth’ of identity of an individual rather than remain limited to the activity.

Again, historically in Western culture there seems to be an inherited power laden mono-discourse of penetrative performance signifying a normal man that these participants recognise as ‘mythic’. Yet, in their talk it is clear that these circulating myths still exert normative pressure that powerfully regulate expectations about gender and sexual performance. This hegemonic account of maleness is contested by contemporary psychological work such as Butler (1990), Edley and Wetherell (1997), Wetherell and Edley (1999) and more recently Richards and Barker (2013). Informed by a post-structuralist approach to gender, Richards and Barker (2013) make visible how the normative rules about sex and gender could be contested to embrace normalised variability as opposed to the rigid expectations illustrated above.

4.3 Therapeutic subject positions in relation to working with MSD

As noted in Chapter Three (see section 3.3.4) the subject positions identified in this analysis are specifically concerned with therapeutic discourses in relation to constructing and working with MSD, particularly highlighting their diverse power relations for constructing practice. The three subject positions illustrated here ‘the

Sexpert', 'the Amateur' and 'the Critical Practitioner' present three different power related subjectivities for practice in terms of what is enabled and constrained in these participants' talk.

4.4 The therapeutic subject position of the Sexpert

Interestingly four participants, and two in particular, mobilised this therapeutic position that located them in definite expert truth claims about how to understand and work with MSD as illustrated below.

4.4.1 The exclusivity of the Sexpert

In this subjectivity these CoP participants constructed working therapeutically with MSD as requiring specialist knowledge and skills.

Extract 7

"...some people think that, they can just do it, um, (mm) say "Oh well I'm-I'm a trained [generalist] therapist so I can just treat this sexual dysfunction that's come along" and I totally disagree with that. " (Sarah, L496-499)

Extract 8

"...I do definitely think that there is a place for it as a specialist area, um, because it is a complex area to work in (hm-mm) and, um, I think the skills that you gain from working in it, you gain over, you know a period of time and through experience..." (Charlotte, L389-393)

Extract 9

*...if I could pass on one thing it would be ask about sexual difficulties,
all generic therapists, counsellors should ask and refer on, you know,
to-to someone who can help. (Sarah, L783-786)*

Drawing on this discourse of expertise, both Sarah and Charlotte appear to construct a hierarchical power relationship between sex “*specialists*” and “*generic*” practitioners. In their talk, specialists are produced as competent and skilled in working with this presenting problem, and by contrast deskill and exclude the generalist from this area. To legitimise these exclusive claims to MSD, Charlotte objectifies MSD as a “*complex area*” requiring “*specialist skills*” and knowledge, mobilising a discourse of expertise to achieve this. By implication this subject position seems to limit or devalue the potential benefit a CoP with general therapeutic experience may offer a client presenting with this problem. It also begs the question of ‘in whose interests’ is the talk from this position i.e. in the clients’ or the practitioners’ themselves? Interestingly, Sarah and Charlotte both reported significant clinical experience working with MSD and specialist training related to sexual problems beyond their CoP training, which may facilitate their mobilisation and privileging of the Sexpert position. The implication of these factors and this opportunistic research are considered further in Chapter Five (see section 5.3.2).

The bold confidence of Sarah’s claims seem to be further valorised by a moral discourse of “*should ask and refer on to someone who can help*” that again reinforces the truth claims of categorical difference between generalists and specialists and ethically working with sexual problems. Here the power games of dominance and exclusion are deployed by this Sexpert position.

4.4.2 The objectification of MSD in diverse knowledges

The Sexpert therapeutic subject position is illustrated here by interrogating these participants' uses of expert knowledges. As discussed in Chapter One, CoPs are resourced by and familiar with diverse expert therapeutic models through their trainings. Interestingly, the subject position of the Sexpert that is illustrated here, appears to objectify MSD distinctively in discourses deployed as true and exclusive.

- **MSD only understood in relationship**

Extract 10

*"...there's a lot you can do with a man on his own, but I firmly believe that it needs to be treated in the relationship, both partners present."
(Sarah, L447-449)*

Extract 11

"...so f-for me it wasn't, you know, that he had low sexual desire he had low sexual desire in this relationship..." (Arlene, L92-93)

Extract 12

"...he wasn't in a relationship, and he was only having casual, um, contact it didn't really feel like there was much more I could do with him and I said to him, I suggested that, er, he came back to me (hm) when he was in a relationship" (Charlotte, L147-151)

In the above extracts the participants seem to speak from an expert position of certainty about MSD as being worked with only in relationship. For example,

Sarah states *“I firmly believe that it needs to be treated in the relationship, both partners present”* glossing the relationship of the sexual couple as the problematic site and focus of treatment, as opposed to the male’s body or mind. Sarah’s bold assertions of her claims indicate she is focused on just one way of working with this problem in this moment.

In the above quote Charlotte appears exclusively subject to working with MSD in relational terms *“suggesting”* that her client *“come back to”* her *“when he was in a relationship”*. In this talk the lack of the relationship is glossed as limiting therapeutic success, rather than challenging her to explore other possible causes from a ‘not knowing’ position. When mobilising the Sexpert position in this particular construction of MSD the client has the potential to be stigmatised for being single or having casual sexual relations, and excluded from psychological treatment. This illustrates Berry and Barker’s (2015) caution that practitioners need to be aware of the regulatory power of heteronormative discourses in understanding sexuality and its problems.

- **MSD as caused by performance anxiety**

Another truth claim of the Sexpert subjectivity is illustrated in how some of these participants deploy the discourse of performance anxiety.

Extract 13

“They’re [clients] focussing on, on performance and not, not feelings (hm-mm) and obviously there this whole thing with nitric oxide, you know, once someone gets anxious in a situation like that, um, you know the nitrous oxide, e-e-e-e an erection is impossible.” (Sarah, L388-391)

Extract 14

“...we talked about ways to break into that kind of vicious cycle, in terms of the anxie- um, performance anxiety in terms of challenging his thoughts, um, his negative thoughts, the main one being obviously “that it’s not going to happen, you know, I’m not going to be able to perform”. (Charlotte, L137-141)

In these extracts participants draw on diverse expert knowledges to resource their understanding of performance anxiety. However from a discursive perspective the ways in which they talk illustrate a ‘Sexpert’ subject position due to their respective reliance on one frame of intelligibility that locates each of them rigidly in one way of thinking about this problem. For example, Sarah draws on a medical discourse referring to nitric oxide as causal of this problem whereas Charlotte focuses on a CBT psychological approach to anxious thoughts and sexual failure. It is argued that these singular ways of glossing the aetiology of MSD position these CoPs, who can draw on an integrative and pluralistic repertoire of knowledges, in reductive and singularly limited ways of understanding their clients.

Performance anxiety, as discussed in Chapter Two, although a foundational expert concept of Master and Johnson’s (1970) understanding of MSD, appears to have retained cultural influence in contemporary psychological fields. However, in these participants’ accounts the Sexpert subject position seems to essentialise this complex construct into a singular expert discourse.

- **MSD understood in psychodynamic processes**

A further example of the Sexpert's definitive use of theory is illustrated in the deployment of psychodynamic discourses by these CoP participants.

Extract 15

"I find myself saying things like I don't think anything other than proper attachment based object relations psychodynamically informed therapy can possibly work, because everything else just really doesn't."

(Stefan, L146-148)

Here Steffan illustrates the definiteness of the Sexpert position by valorising attachment object relations theory as being the only effective therapy for working with MSD. The discursive power of psychodynamic discourse is already culturally powerful in itself as a categorical deterministic way of pathologising dysfunction and is here rendered more potent by being deployed from the Sexpert position of a singular definite truth claim.

Extract 16

"when we look at that, um, specifically something not working your penis, er, tha-that's just a tiny bit of what we are actually seeing that behind which I think is a huge, often a huge problematic dynamic that is about love and sex and intimacy and autonomy and potency and power." (Stefan, L322-327)

Extract 17

"...that the-the, sort of the experience of disempowerment was being symbolised through, you know, through his erectile dysfunction." (Elizabeth, L353-354)

Extract 18

“...I take it as, um, again as any other symptom, as any other difficulty, um, (.11) for me yeah it’s just the way, er, the conflict rise. It’s just one of the possible ways.” (Nicole, L295-297)

The discursive power game of hegemony is employed by this Sexpert position in mobilising psychodynamic discourses related to MSD. For example, it is variously objectified as “a *problematic dynamic*”, an example of “*disempowerment*” or “*conflict*”. Here Nicole uses a psychodynamic theoretical frame that seems to shut down other ways of thinking about MSD, while reductively conceptualising it as similar to a variety of presenting “*conflicts*”.

Overall, deployment of the Sexpert position within these diverse discourses appears to provide these CoPs with a professional position from which to talk about their competence and confidence that is unmasked as possibly reductive, inflexible and entrenched. As illustrated in the extracts above, participants mobilising the Sexpert subjectivity appear to deploy their therapeutic knowledges authoritatively yet exclusively, which seems to permit them expert practice rights for working with MSD. By contrast to the definite truth claims in the talk of participants characterising the Sexpert position were the accounts of participants who occupied the Amateur position.

4.5 The therapeutic subject position of the Amateur

The second therapeutic subjection position identified was called the ‘Amateur’ position. This way of talking vividly contrasted with the authoritative position of the Sexpert and is characterised by a wavering insecurity about working therapeutically with MSD. In deploying this position these participants appear to

be overwhelmed by the multiple constructions of MSD, which seem to be associated with an uncomfortable uncertainty.

4.5.1 MSD objectified as ‘complex and other’

The distinctive markers of the Amateur position were identified by how some participants objectified MSD as a complex, difficult and ‘other’. The distinctive power relations are observable in the ways in which participants talked about their insecurities as practitioners and the rationale they gave for extricating themselves from this work and referring on.

Extract 19

“...I mean from my readings certainly, there was a lot of CBT or behavioural stuff, there was, there, there was nothing qualitatively different and yet, to me, it still remains something quite, quite distinct, quite mysterious, quite complex, something that probably requires some sort of specialist training.” (Rosalind, L220-224)

Extract 20

“...it feels that sex and its problems are quite discreet and marked off. It’s over there, somehow separate and different from other presenting problems a-a-and issues.” (Dominic, L86-89)

Extract 21

“...it felt a bit charged and a bit fraught and I-I wasn’t quite sure how comfortable I would feel (mm) with that topic...” (Rosalind, L98-99)

In the above extracts, these CoP volunteers seem to produce sex, MSD and its specialist treatment as ‘other’, ‘unknown’ and “*discreet*”, which appears to distance them as competent practitioners to this problem account. For example, in Rosalind’s talk glossing MSD as “*quite mysterious*” seems to be associated with the negative feelings of discomfort and fraughtness.

As an objectification of MSD these accounts position the speakers as subject to producing themselves as de-skilled, unknowing and insecure practitioners. Considering the extant literature reviewed in Chapter Two (see section 2.3.7) this subject position could be discursively resourced by the move from the 1970s onwards to the professionalisation of sex therapy as a distinct expertise that excludes generalists.

4.5.2 Am I equipped?

In the deployment of the Amateur position participants appear to produce themselves as uncertain in their competency to work therapeutically with male sexual dysfunction.

Extract 22

“...I was also thinking I hope I’m not wasting his time, you know, by thinking that’s it’s psychological, (hm-mm) because I am not encouraging him to go and be checked by a doctor.” (Nicole, L235-238)

Extract 23

“ I guess that’s where my doubt creeps in for this client, in the fact that there is a complex interaction between relationship with partners, relationship to his own body, and relationship to his sense of self, and it’s difficult to know where’s the best place to start.” (Dominic, L126-130)

Extract 24

“...I felt there was a whole body of knowledge out there that I could sort of skim through but I would never be able to appropriately to the extent of, of being, as helpful as someone who devoted their, their life doing that [sex therapy].” (Rosalind, 176-179)

These practitioner accounts illustrate the Amateur position as contesting and unsettling their competence as practitioners by mobilising an “am I equipped?” discourse. For example, Dominic provides a saturated account of his position as “doesn’t know the best place to start”, glosses the problem as a “*complex interaction*” and his “*doubts creep in*”. As an Amateur subjectivity these personal practitioner truth claims do not provide him with any alternative competency accounts to unsettle this position. Another discursive practice exemplified by Rosalind illustrates a polarised construction of expert as “*someone who devoted their, their life to doing that [sex therapy]*” contrasted with this Amateur position as a “*sort of skim through*”. Such a splitting or comparison of competencies locates her in an enfeebled locale that seems impossible to remediate. This discursive dilemma is of particular interest to the CoP who is obliged to negotiate multiple knowledges and cannot be an expert in every presenting problem, yet needs to have a professional confidence to be able to resource themselves as required.

4.5.3 Deference to the specialist

Furthermore, by talking in this deskilled way from this Amateur subject position, some participants seem to locate themselves as subjugated and inferior in a hierarchical power relationship with others who are specialists in the profession. One example of this hierarchical power was illustrated by their reference to a willingness to refer on to experts in managing this presenting problem.

Extract 25

“...I was aware that if that proved to be insufficient I could, could refer on and-and have no problem doing that.” (Rosalind, L481-483)

Extract 26

“...I wasn’t too worried about that because I thought that if after a while the therapy’s not working he c-can a-at any time he can really go and see a specialist and be checked in a way.” (Nicole, L233-235)

Extract 27

“...he had had some specialist help before he came to us so, um, so he had been to see a-an expert, um, in sexual dysfunction and he had had various tests and everything done and so he had already had that help...” (Elizabeth, L442-445)

While deference to the specialist is increasingly a common practice in contemporary healthcare, this Amateur subject position illustrates how some of these practitioners employ the referral discourse to possibly appease their professional insecurities. For example, Rosalind states that if her work proves “insufficient I could, could refer on”, and Nicole talks about “if after a while the

therapy's not working [...] he can really go and see a specialist". These examples illustrate a deferential inferiority in this subjectivity that reflects the insecurity of this position in the wider professional hierarchy. Interestingly, in the context of the interview Elizabeth seems to gain therapeutic security by noting that her client had already "*been to see an expert in sexual dysfunction*" therefore legitimating her work as viable.

Overall, this Amateur subject position seems to offer a discursive space whereby participants can legitimate an easy 'escape' from the demands of this work as illustrated by the apparent readiness in their talk to refer their client to specialist help. Rosalind has "*no problem*" doing this and Nicole "*wasn't too worried about that*". Discursively this may be indicative of the constructed otherness of sex that easily justifies specialist help as noted in Chapter Two.

In summary, I have argued that these CoPs deploy the therapeutic position of the Amateur that seems to subjugate them in relation to specialist expertise knowledge and skills. This deference that is illustrated by their objectification of MSD and sex as 'complex, multiple and other' produces them as de-skilled practitioners. Furthermore, awareness of the multiple discursive resources objectifying MSD seems to overwhelm rather than empower those who deploy this subjectivity.

4.6 The therapeutic subject position of the Critical Practitioner

The third discursive therapeutic subject position identified in this data is titled the 'Critical Practitioner'. Contrary to the previous subjectivities this discursive position seems to locate participant speakers as demonstrating more fluent and confident

uses of language for negotiating multiple expert knowledges to engage with the complexities of working with MSD.

4.6.1 Meta-perspectives for knowledges

Speaking from a meta-perspective is a definitive feature of this subjectivity as illustrated here:

Extract 28

“But I suppose it comes down to the acknowledgement that they are all just metaphors of the mind and different ideas and ways of thinking of about sexual dysfunction. I guess it’s about finding out which one works for the client.” (Dominic, L132-135)

Extract 29

“...yeah not being fixed in my interpretations, it could be something different. It reminds me about the cultural differences...or perceptions of mental illness and that it depends on where you are from. It could be different or change.” (Celeste, L452-455)

For both of these participants knowledges are not produced as real or fixed. They each achieve this remove from factual truth claims by diverse discursive strategies. For example, Dominic seems to understand knowledges as “*metaphors of the mind*” rather than fixed causal truths which enable him to transcend the veracity of competing claims. He can also think pragmatically about choosing which therapeutic model will best “*work for the client*”. This locates him in a more flexible and confident position to decide how to treat MSD for the particular client he is presented with.

Again Celeste mobilises the meta-position of “*it could be something different*” that flexibly enables her to inhabit or evacuate different knowledges. Interestingly she deploys a cultural diversity metaphor to escape definite truth claims about mental illness, which she likens to her therapeutic understandings of MSD: “*It reminds me about*”. By implication Celeste constructs knowledges as dynamic, mutable and contextual.

4.6.2 Exercising critical practice

Within this subjectivity CoPs’ talk appears to take a more considered and critical perspective to their therapeutic practice. This is illustrated by how these participants specifically do knowledge discursively to scaffold their therapeutic thinking.

Extract 30

I-I think it is hopelessly reductionist to simply reduce male sexual dysfunction to, er, biology. It's not that biology isn't involved, and indeed it often it is, well it always is, but, um, but there are complexities and psychological realities around sort of (.3) around the biology that needs to be thought of. (...) But there is always a risk as much as there are people in the medical profession can be at risk by attending to the psychological, we might equally miss some of the biological factors
(Pascal, L178-183)

Here Pascal illustrates his evaluative process in exploring alternative accounts and considering their relative value. It is argued that he skilfully combines vernacular and expert language in referring “*hopelessly reductionist*” to capture his

sense of the limitations of dualist constructions of the mind/body. He appears to exercise discursive inclusivity, deploying a 'both/and' rather than 'either/or' construction, which is different from the previous therapeutic subjectivity above that appeared to mobilise polar positioning rather than being able to negotiate both. Inferentially Pascal positions himself differently to transcend the dangers of such polar thinking by critiquing the riskiness of such dualisms.

Extract 31

"First of all I thought about looking at his performance anxiety and the potential of a vicious cycle being maintained, but then in light of his complex relationship I thought it would be just addressing the symptom, and it would be more useful to look at the meanings and emotions of his relationship, rather than the CBT angle which would have focussed more on the sex." (Arlene, L493-495)

Extract 32

"...thinking about the client there were some choices. Do you go for an intrapsychic, more interpersonal focus or a CBT approach? CBT can get some symptom amelioration and that in itself can kick start the relationship, so you don't have to worry too much about the underlying sources...(...) I found that the CBT idea of normalisation was really useful to begin with for this client, to reassure and reduce anxiety, but then I think, also using the psychoanalytic notion of a manic defence helped me, and him... understand the motives of his behaviour more, so both understandings helped me in, in-in working with the patient." (Elizabeth, L428-432)

Extract 33

"I'm very much interested in psychoanalytic thought, but depending on what the presenting problem will determine what I use. For example, from my experience I-I tend to find with couples, particularly with psychosexual stuff, that (.3) solution focussed work can be useful as it's about bringing them together, improving the relationship, getting them o-o-n the same page and moving towards a goal and can be quite quick. That's why I also bring in some behavioural work, which can, can address the problem on a different experiential level. The psychoanalytic ideas are useful, but I tend to use them more if we hit an impasse." (Pascal, L30-33)

From the above extracts it is argued that from this Critical Practitioner subjectivity these participants appear to confidently negotiate multiple therapeutic knowledges by exercising a critical perspective to these discursive resources. It is argued this strategic evaluative practice allows for a skilled movement between discourses. For example, in Arlene's therapeutic talk of working with a client she consciously considers a CBT approach mobilised by a 'performance anxiety' discourse, but decides that it would be limited to the "symptom" and "more focussed on sex", as opposed to deploying an interpersonal perspective, which she glosses as addressing causation and thereby more effective. This resonates with contemporary clinical perspectives that critique some therapeutic knowledges as symptom focussed rather than aetiologically problem orientated.

In travelling across knowledges, there seems to be a qualitatively distinct way of doing talk. For example, Elizabeth and Pascal exemplify the contemplative and evaluative stance characterising this subjectivity, which appears to distance them

from the potential domination of any one therapeutic account of MSD. This seems to allow them to travel purposively between therapeutic accounts and models of the phenomenon and aid their decision-making. This is further illustrated by Elizabeth's talk about her therapeutic practice with a client, where she deploys this critical perspective to both the CBT and psychoanalytic models as, "*I found that the CBT idea of normalisation was really useful*" as was the "*psychoanalytic notion of a manic defence*". Such eclectic juggling of constructs from diverse knowledges seems to be guided by an evaluative pragmatism 'what works for what' that is of relevance to integrative, eclectic or pluralistic practices employed by CoPs.

Reflecting across the interviews conducted, participants who spoke from this Critical Practitioner subjectivity seemed to talk with familiarity and confidence when referring to various uses of expert knowledges in their work. Consequently MSD seems to be objectified distinctly from the previous subjectivities as challenging yet knowable and thereby treatable. This construction contrasts with the truncated discourses of the latter two subjectivities that either adhered to one account or was overwhelmed. Furthermore, this appears to resonate with the CoP literature which argues the CoPs' professional identity is designated by their skilful and critical approach to multiple and contrary epistemological positions and knowledges (McAteer, 2010; Strawbridge & Woolfe, 2010).

4.6.3 Reflecting on limits

This therapeutic subjectivity was also characterised in how these CoPs spoke about the limitations and management of their therapeutic knowledges and practice.

Extract 34

“... if you’re diabetic you might not get an erection, if you, er, take certain high blood pressure tablets you might not get an erection but I wouldn’t know enough that if they mentioned the name of the drug I would be able to tell them that. So I would tell them that there might be physiological reasons why this is happening and to go to the GP to get checked out in that respect, so we can work in therapy in confidence.”
(Arlene, L224-230).

Extract 35

“...so currently we use the squeeze technique but I know that here is, um, there’s been some new literature recently today that-that- say it’s not successful and, um, there’s some other ideas around how to, um, treat premature ejaculation and that’s something that we’re trying to move with. [...] it’s something that me and my colleagues would like to do, to get some further training in it, because I think, um, that things are changing all the time and, um, treatment, er, treatment, er, interventions are changing all the time.” (Charlotte, L298-301)

These participants appear to maintain professional competency and power by reflecting on the deficits of their therapeutic knowledges and professional skills, which seems to open a space for recruiting additional resources to meet perceived need. This appears to empower rather than deskill these participants. It is argued that these participants exemplify a discourse of ‘awareness of deficits’ being glossed as a strength rather than weakness that seems to enable them to sustain confidence rather than become insecure.

For example, Arlene resources herself with additional expertise in her acknowledgment of the limits of her pharmacological knowledge: *"I would tell them that there might be physiological reasons why this is happening and to go to the GP to get checked out in that respect"*. It appears she confidently positions herself alongside biomedical expertise as a resource to be consulted rather than deferred to.

Alternatively Charlotte appears to manage her limits by normalising them. Further by glossing treatment interventions as *"changing all the time"* she enables herself to dynamically be open to and work with them, rather than construct herself as de-skilled. In respect to the discipline of counselling psychology, this could be framed by a discourse of 'continuous professional development' which acknowledges the enduring mutability and learning required in being a competent practitioner (BPS, 2001).

Extract 36

"I'm pretty confident working with psychosexual stuff and have a lot of experience with it, however, if there is a more specialist, um, need, something I feel, I think what I'll do then is to refer to-to psychosexual colleagues with a particular interest or-or specialist area." (Pascal, L385-387)

Although Pascal positions himself as competent in his claims of 'confidence' and 'experience' in working with psychosexual issues he does not gloss his therapeutic skill as infallible, suggesting a confidence to consult rather than as deployed by the Sexpert's uncritical confidence. Furthermore, in his discussion of referral to 'specialists' it appears a considered process, rather than a reactive safety position

as illustrated in the Amateur subjectivity. This seems to allow this participant to maintain a professional confidence in acknowledgement of his limitations.

In summary, these CoPs who mobilised the Critical Practitioner position seem to apply a meta and critical perspective to the therapeutic knowledges and practices that resource their accounts of MSD.

4.7 Overall summary of analysis

Overall, from the interrogation of these CoPs' therapeutic accounts I argue that MSD is a problematic discursive phenomenon in the discipline of counselling psychology. The application of a post-structuralist perspective to these participants' truth claims of working with MSD illustrates the opaque and power-laden nature of language. Interrogation of these participants' use of language highlights how they appear to draw on multiple and diverse therapeutic accounts of MSD in nuanced ways, which were seemingly associated with distinct ways of being and working with MSD. This supports the argument that CoPs could benefit from paying attention to their therapeutic talk via a critical reflexivity, with the aim to raise awareness of the power games they may unknowingly be located in.

Chapter 5

Discussion

“The scholar’s task is not to get it ‘right about the nature of the world’,
but to generate understandings that may open new paths to action”.

Gergen, 2009: p. 81.

5.1 Introduction to Chapter Five

This final chapter discusses the research’s findings produced to answer the question: “*What are the discursive power relations in counselling psychologists’ therapeutic accounts of working with male sexual dysfunction?*” The answer produced and presented in this research is one of the many possible from these 10 CoP participants’ therapeutic accounts. From this analysis MSD, as talked about by these 10 CoP participants, is highlighted as problematic due to being multiply resourced by diverse and contradictory power-laden constructions. Overall, it is argued that this research contributes to raising CoPs’ awareness to the power of their talk, how they can become subject to expert knowledges and seemingly positioned in the complex discursive matrix constituting MSD and its therapeutic treatment.

In this chapter, I firstly discuss and evaluate the contribution of these research findings to the field of counselling psychology. Secondly, I evaluate the application of Foucauldian discourse analysis and the use of a poststructuralist epistemology for examining this topic and include further reflexive commentary as a CoP researcher. Lastly, I consider recommendations for future areas of research generated from completion of this discursive work.

In discussing the findings of this research it is important to emphasise, that in honouring its post-structuralist epistemological position, no claims are made to the material or causal effects of increasing the awareness of the power games contingent with the constructions of MSD (Edwards, Ashmore & Potter, 1995). The main contribution of this research, therefore, is to remain within the limits of discursive commentary and allow the readers' awareness to be raised of the networks of power operating in their own therapeutic truth claims of MSD. This has been achieved by the rhetorical power of argument and illustrative participants' quotes in Chapter Four (O'Callaghan, 2010; Willig, 2013).

5.2 The research findings and their possible contribution to counselling psychology

The main contribution of this research is that it offers a critical resource for CoPs to enhance their reflexive gaze allowing them to examine their professional therapeutic truth claims and practices in relation to working with MSD. This has been achieved by providing a rationale for this proposed study in Chapter One where I contested some of the extant knowledges resourcing MSD that are circulating and available to CoPs. In Chapter Two I presented a genealogy that critically reviewed the diverse psychological and therapeutic knowledges relating to MSD that indicated the need for an analysis to make visible the nuanced complexities of contemporary therapeutic talk about this phenomenon by CoPs.

The analysis presented in Chapter Four produced two aspects of analytic interest, firstly highlighting the wider contextual circulating discourses about MSD that made visible the regulating norms of male sexuality and its tacit assumptions. Secondly, the analysis identified three therapeutic subject positions that will be

discussed here in relation to their implications for counselling psychology and the related MSD literatures.

The first key finding interrogates the wider contextual expectations, illustrated by two discourses that appear to regulate male sexuality and identity by producing mythic norms related to sexual performance as masculinity. These particular discursive constructions resourced each of these 10 CoPs' therapeutic accounts and interestingly are glossed as mythic by them, yet powerfully influential in their clients' ideas about MSD. This mythic distancing has been addressed in the psychological and therapeutic literatures (e.g. Brooks & Elder, 2012; Zilbergeld, 1999) to which these CoPs are also subject. It could be argued that while experts such as CoPs seem to be privy to recognising and critiquing the power of mythic claims, this position of undoing gender (Butler, 1999) could be vernacularised for the ordinary guy in the street.

The second main finding made visible diverse therapeutic subject positions deployed by these CoP participants that located them in distinct power related constructions of MSD. Of particular interest in the analytic commentary was how these CoPs mobilised the available expert knowledges that enabled them to inhabit or evacuate being certain (the Sexpert), insecure (the Amateur) or knowingly negotiating (Critical Practitioner) these knowledges. It is important to acknowledge that these three subjectivities may be deployed by any individual and each affords its own permissions and constraints. It is proposed that this finding highlighting these diverse power related practitioner spaces makes a contribution both to the therapeutic, and specifically, the CoP literatures.

This contribution may be understood as providing a meta-perspective on one's talk about a phenomenon such as MSD that can inform a personal reflexivity in terms of knowledges being deployed and professional contexts being negotiated. For example, the positions of Sexpert and Critical Practitioner variously privilege expert therapeutic knowledges within diverse power relations for subjectivity. While the Sexpert may engender confidence in the client by being definite in their expertise, the Critical Practitioner, while confident in negotiating the complexities of clinical decisions, if expressed, could confuse rather than assure a nervous client. This illustrates that no one subject position is the preferred or best way to talk on all occasions. Here this analysis may be understood as providing a self-questioning technique to one's own previous assumptions and truth claims (Foucault, 1984/1991).

This perspective may also be employed by CoPs interrogating the traditional literatures on MSD as reviewed in Chapter Two and exemplified by the more recent social constructionist/post-structuralist contributions of Tiefer (2004) and Kleinplatz (2012). By situating this research in counselling psychology it also aims to contribute to addressing the broad dearth of research relating to sex, its problems and therapeutic treatments in this professional domain. As argued in Chapter One, CoPs may encounter the presenting issue of MSD in a variety of contexts and services, and as such this research may offer a useful resource to inform about the complexities of this phenomena. As Chapter Four highlights, the discursive objectification of MSD as 'other' appears to characterise the deskilled and subjugated Amateur position, and therefore this research could offer alternative discursive locales to occupy which do not marginalise or evacuate sexual issues from counselling psychology or generalist psychotherapy (Binik & Meana, 2009).

5.3 Evaluation of this research

In this section I evaluate the use of an FDA methodology and the method deployed to address the research question. The choice to implement an FDA methodology is in itself limiting as it shapes the parameters of what can be made visible and the claims of the knowledge it produces (Willig, 2013). However, any other methodology would have also imposed its own particular constraints due to their underpinning philosophical framework. Firstly, I critique the limitations of a Foucauldian approach. Secondly, I discuss the possible implications of the heterogeneity of the volunteer CoPs interviewed and, lastly, I revisit the issue of researcher reflexivity in this post-structuralist research.

5.3.1 A critique of Foucauldian discourse analysis

A Foucauldian analysis seeks to examine the power of talk and cultural resources that construct social and psychological realities. Because of the lack of standardised methodological guidelines for conducting an FDA in psychological and therapeutic research, analyses have interrogated power relations operating at different levels and diverse sites. Avdi and Georgaca (2007) note that discursive research has been criticised by clinicians for being theory laden and somewhat removed from informing therapeutic practice. This criticism is most likely a response to the analyses of macro power relations, such as produced by Rose (1985) and House (2003), who interrogate the discursive institutions and regimes of truth of the psy-disciplines. Thus these works may appear of limited clinical use to the immediate therapeutic interaction. However, Avdi and Georgaca (2007) argue that research which strikes a balance between micro and macro operations of power by focusing on the interface between subjectivity, therapeutic interaction

and wider social processes can increase clinical utility whilst retaining a critical edge. Although this research cannot comment on the therapeutic interaction of treating men with MSD by these participants, it has attended to wider and local power relations in its genealogical perspective (Chapter Two) and analysis of these 10 CoPs' talk (Chapter Four). From these analytic perspectives it offers a critical resource for CoPs' to facilitate the development of a reflexive gaze underpinning their clinical work.

The turn to language has initiated continuing debates about the relationship between discourse and material reality with each perspective critiquing the often-polarised counter position (Willig, 2013). This research has sustained a relativist position as articulated by Edwards, Ashmore and Potter (1995) and as such makes no claims to the material or non-discursive world, or how this research may directly affect practice. Its focus has remained on the social production of knowledge, the power games of discursive resources and the positionings made available in these 10 CoPs' accounts of working with MSD. Hook (2007) criticises this emphasis on text and language arguing that it neglects the links to materiality of practices and the physicality of power effects that made Foucault's work so influential. However, in line with the postmodern tenets of counselling psychology and the post-structuralist perspective of this research, I concur with Willig (2013) who argues that psychological research is enriched for its methodological flexibility, which allows the emphasis of different analytic concerns.

Another possible limitation of this research is its assumption that subjectivity can be theorised on discourse alone. As illustrated in Chapter Four, three distinct subject positions appear to be characterised by the mobilisation of multiple discursive resources in nuanced ways. Hollway and Jefferson (2000) argue that

further explanation is required to account for the investment and attachment particular individuals have for certain subject positions. For example, in relation to this research why do certain participants seem to occupy the Amateur subjectivity more than the Sexpert subject position? Hollway and Jefferson (2000) employ a psychoanalytic framework for making sense of these investments. However, I find it incongruent with a post-structuralist approach to privilege a certain explanatory framework and agree with Davies and Harre (1999) that an individual's life history and experiences are sufficient enough to explain the attachment and emotional meanings of specific positions.

Furthermore, FDA has been criticised by Edley and Wetherall (1997) for its reification of discourse as an object independent from its speaker. As highlighted in Chapter Three (see section 3.2), FDA emphasises the 'top-down' power relations of language rather than the action and strategic skill of the participants' use of language. Whilst this research agrees that people are both the products and producers of discourse, an FDA approach was specifically chosen to highlight the analytic interest of how these participants were 'talked by' and made a subject of the language they use. Therefore an examination of these participants' discursive skills in managing their stake and interests were not included in this research.

Contemporary criticism of FDA proposed by Dickerson (2012) states that as a methodology it is theoretically rich but data thin. However, it is argued that this research provides enough data to substantiate a convincing argument and, as Willig (2013) claims, it is the reader not the author, who will decide whether or not a particular analysis has sufficient rhetorical power.

5.3.2 A critique of opportunistic participant sample

As the results produced from this research are considered a co-construction between the researcher and the researched it is important to critique the opportunistic participant sample. It could be argued that the findings were constrained by the contributions of these participants, and that other CoPs may have provided different accounts. However, from a post-structuralist perspective this is not a concern because any talk by CoPs potentially offers the opportunity to make an analytic contribution.

When employing small sample sizes for research, such as the 10 participants recruited, a homogenous sample is aimed for. Although this sampling method provided adequately rich accounts from the volunteer participants for the purpose of this research, the group did present a degree of diversity as presented in Chapter Three, Table One. Willig (2013) cautions against the use or inclusion of demographic information in discursive research as they may become treated as social categories that essentialise and reify experience, and therefore counter to the post-structuralist stance. Although these demographics may shape the limits of what is discursively possible for some people at particular moments in time, such categories are considered to be social constructions, and consequently mutable and dynamic. However, certain aspects of the heterogeneity in the sample will be discussed to provide a possible frame of meaning and context to the research.

This research is argued to be particularly relevant to CoPs due to the diverse and multiple knowledges drawn on to characterise the profession (McAteer, 2010). However, through the interviews it became apparent that these participants were eclectic in how they defined their theoretical frameworks, differed in the contexts in

which they worked with MSD, and their further therapeutic trainings related to sexual problems. This appears to reflect the noted diversity of employment settings and opportunities for CoPs, as well as the breadth of ideas that come under the scope of counselling psychology (Strawbridge & Woolfe, 2010). Further research would be needed to explore the possible benefits and limitations of this heterogeneity of therapeutic knowledges operating in and as counselling psychology.

Six of the volunteer participants detailed additional specific training related to sexual problems that was separate from their CoP training. It was noted that two of the participants, Sarah and Charlotte, predominately mobilised the position of the Sexpert. Although speculative, this may reflect these participants are subject to 'specialist expert' discourses promoted by their additional trainings and illustrate vested interests in ring-fencing this client group. As noted in Chapter Two (2.3.7) debate remains about the benefits and constraints of 'sex therapy' as a specialism and further research would be required to fully consider the influence of specialist trainings on CoPs' subject positioning.

Participants ranged in experience of working with MSD from one patient up to treating this issue routinely in their professional practice. Those participants with limited experience, for example Dominic and Rosalind, tended to occupy the Amateur subjectivity and seemed overwhelmed by the competing multiple therapeutic constructions available to them. However, Dominic, as noted in Chapter Four, also inhabited the Critical Practitioner subject position indicating the fluidity of subject positions. More research would need to be conducted to examine the possible discursive influence of discourses of 'experience', deconstruct its meanings and possible implications for subject positioning.

Lastly, the volunteer CoPs had experience of working with MSD in a range of settings including private practice, NHS and the charitable sector, as well as generalist and specialist counselling services. From the interviews it became apparent that some organisations had a clearer framework for approaching therapeutic work with MSD and some participants described how the limits of their service (e.g. number of sessions) had constrained their practice. Future discursive research exploring the organisational setting and context and how this may shape CoPs' therapeutic treatment of MSD could yield an interesting web of power relations.

5.3.3 Researcher reflexivity revisited

Having considered the role of researcher reflexivity previously in Chapter Three (see section 3.4). I now provide further reflexive commentary addressing the data collection, analytic process and the research methodology as a whole. It is acknowledged that from a post-structuralist perspective the researcher influences every aspect of the research process and that every choice is inevitably biased (Harper, 2003). For example, a researcher's attention will be drawn towards some phenomena to the exclusion of others. FDA acknowledges this interpretative nature of knowledge, and although transparency can never be reached as individuals are always multiply and dynamically located by talk, researcher reflexivity may offer further critique of the frames of intelligibility and their possible power effects.

It is argued that the CoP profession is taking an increasingly relational position in practice (Woolfe et al, 2010), emphasising intersubjectivity, and the centrality of the therapeutic relationship. This relational stance resonates with the post-

structuralist researcher's conception of interviews as co-created and mutually constructed (Willig, 2013). The postmodern assumptions of counselling psychology has therefore led to the promotion of critical reflection as a valued skill in training and the profession. Foucault's (1984/1991) discursive approach offers CoPs another method of critique that can be applied to their expert psychological knowledges to offer alternative understandings and contest their static assumptions. Specifically, this research has made visible the possibility for reflexivity in therapeutic work with MSD and encouraged consideration of professional positioning, although it is acknowledged that in the Foucauldian tradition, reflexivity itself should not become an end point, as it is an object of discourse itself.

Therefore, this research has required me to interrogate the positions I mobilise as a researcher, as well as the therapeutic knowledges that resource my clinical practice. The semi-structured interviews collected rich enough data in which to identify this research's discursive interests, however, the researcher-researched relationship provided an important point of reflection. The aim of the interview process was to gain access to the volunteer CoPs' therapeutic truth claims of working with MSD, although, the 'truth' of these participants' claims must be viewed sceptically as they were a product of co-construction between the researcher-researched. For example, during one interview I, as the researcher, noted an apparent defensiveness of one participant when exploring an account of a clinical case of MSD they had treated. This highlighted to me, as researcher, the potential of the participants' felt need to self-police their accounts to appear as a competent, ethical and professional CoP participant. Although in contrast, I was also struck by some participants' apparent honesty about their concerns of working therapeutically with MSD, which reminded me of Foucault's confessional

practice (1977/1980), which may be likened to the supervisory process required of training and qualified CoPs.

Utilising a Foucauldian discourse analytic has proven personally and academically challenging, yet a rewarding research methodology, and offers many benefits to CoP researchers (Avdi & Georgaca, 2007). Engagement with the work of Foucault has sharpened my critical gaze to the power-laden constructions of sexuality and sexual function that I was unknowingly subject to. As one is always located within discourse, it was a challenge to remain agnostic to the talk of these participants, and resist becoming subject to their truth claims and therapeutic accounts. For example, I found myself occupying a position of deference when listening to the certain and authoritarian statements that characterised the Sexpert subjectivity. It was difficult to resist and reposition myself in relation to their talk, rather than submit to their mobilised position of expertise. Attempts to remain ironic to these participants' knowledge and be reflexive to my discursive location proved a constant challenge. However, I agree with Snell and Lowenthal, (2008) whom argue that a post-structuralist reflexivity encourages practitioners to reposition themselves to their knowledge, their selves and to their clients in an attempt to see alternative possibilities, and understand that what may be true in one moment may not be true in the next.

5.4 Future research possibilities

This research has focussed on the discursive constructions of MSD and their contingent power games in 10 CoPs' therapeutic accounts of working with this presenting problem. Future suggestions for research in the field of counselling psychology informed by the completion of this study are now considered.

As discussed in Section 5.3.1, Foucauldian informed research has been criticised for having limited clinical application (Avdi & Georgace, 2007) and therefore future research could aim to increase its relevance to the therapeutic encounter. This is of particular concern for counselling psychology, which emphasises the importance of the therapeutic relationship and process (Strawbridge & Woolfe, 2010). A discursive examination of naturalistic recordings (Potter & Hepburn, 2005) of therapeutic sessions of working with men presenting with MSD could generate micro-analyses of the CoP-client interaction in which the rhetorical strategies and discursive power games could be unmasked. Hodges' (2002) study demonstrates the value of an FDA to the therapeutic interaction and illustrates the ethical and power-related transformations of callers' problems by a radio-therapist. Similarly, an FDA of therapy sessions of CoPs working with men presenting with MSD would allow examination of the linguistic power and functions operating in the treatment of this particular problem.

A discursive interrogation of the accounts of men experiencing MSD would be a valuable counter to the prioritisation of the expert therapeutic accounts of CoPs presented in this research. As can be seen from the genealogy in Chapter Two, certain dominant ways of understanding MSD have emerged but it is unclear how closely these relate to the client experience and their sense making of sexual difficulties. Examination of how clients' understand their own MSD would allow the interrogation of the vernacular language and cultural resources, as opposed to expert discourses, and the evolving location of sex and its problems in society. For example, as highlighted in Chapter Four, these volunteer CoPs positioned their male clients as subject to powerful and totalising mythic regulatory discourses of sexual performance and masculinity. However, discursive research by Edley and Wetherell (1997) and Wetherell and Edley (1999) argues the

deployment of nuanced constructions of masculinity by men, thus supporting the need for research to make visible the discursive knowledges and practices in the clients' constructed experiences of MSD.

Identification of the diverse power games associated with the identified three subject positions outlined in Chapter Four appears to mirror the discursive complexity associated with counselling psychology's postmodern ethos. Therefore, how CoPs negotiate the multiple, contradictory and heterogeneous expert knowledges that resource their professional identity and practice are of interest. Rizq (2006) notes the emotional strain trainees may experience undergoing pluralistic and integrative psychotherapy trainings by being subject to competing and contrary models of therapy, whilst Downing (2004) iterates the need for psychotherapeutic practitioners to be able to hold the tension of uncertainty associated with multiplicity. A discursive interrogation of CoPs' accounts of how they talk about managing diverse theoretical models and different conceptualisations of client problems could offer some understanding of how they discursively achieve this.

5.5 Overall conclusions

Michel Foucault's radical reformulation and approach to language, knowledge and power has been applied to 10 CoPs' therapeutic accounts of MSD. This one particular reading of the research offers CoPs a critical perspective to working with MSD, and emphasises the value of increasing CoPs' awareness of the power of their language and the subject positions they may be unknowingly located in. It is argued that by employing a critical approach to their therapeutic and psychological knowledges CoPs may increase reflexivity in their therapeutic work with clients presenting with MSD and other problem accounts.

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RECRUITMENT ADVERTISEMENT

Are you a counselling psychologist with experience of working with at least one client with male sexual dysfunction?

If so, you are invited to take part in a study exploring how counselling psychologists (qualified or in-training) think about and work with clients presenting with male sexual dysfunction (e.g. male erectile dysfunction, premature ejaculation, hypoactive sexual desire disorder).

The research aims to explore how counselling psychologists make sense of male sexual dysfunction and how this informs their therapeutic practice. Participants need to have experience of working with at least one client who may have been affected by male sexual dysfunction. Participants will be interviewed for approximately 60 to 90 minutes at a time and location convenient to themselves.

This research is part of the completion of a professional doctorate in counselling psychology at the University of Roehampton, where I am a third year trainee. If you would like to participate please contact Lee Jones at the following: jonesl28@roehampton.ac.uk or on XXXX XX XX XXX.

This research has been approved through the procedures of the University of Roehampton Ethics Committee and is supervised by Dr Jean O'Callaghan (J.Ocallaghan@roehampton.ac.uk).

Appendix 1b – Participant Recruitment Email Advertisement

Dear Dr XXXXXX

Are you a counselling psychologist with experience of working with at least one client with male sexual dysfunction? If so, I am interested in hearing from you about your experience.

My name is Lee Jones and I am a third year trainee counselling psychologist at the University of Roehampton. As part of my doctorate I am researching how counselling psychologists make sense of male sexual dysfunction (e.g. male erectile dysfunction, premature ejaculation, hypoactive sexual desire disorder) and how this informs their therapeutic practice.

So if you have experience of working with at least one client affected by male sexual dysfunction I would like to invite you to take part in an explorative study. This would involve a recorded interview of approximately 60 to 90 minutes at a time and location convenient for you.

If you would like to get involved or have further questions please contact me at jonesl28@roehampton.ac.uk or on XXXX XX XX XXX.

This research has been approved through the procedures of the University of Roehampton Ethics Committee and is supervised by Dr Jean O'Callaghan (j.ocallaghan@roehampton.ac.uk).

Yours sincerely

Lee Jones
Trainee Counselling Psychologist
University of Roehampton

E: jonesl28@roehampton.ac.uk
M: XXXX XXXX XXX



INFORMATION SHEET

Counselling Psychologists' Constructions and Practices Related to Male Sexual Dysfunction

Dear Reader,

My name is Lee Jones and I am conducting research on how counselling psychologists (qualified and in-training) construct male sexual dysfunction. This research is conducted as part of my Professional Doctorate in Counselling Psychology at the University of Roehampton.

What is the purpose of the study?

Clients may present with the problem of male sexual dysfunction to Counselling Psychologists. This presenting problem has little research or literature within the domain of Counselling Psychology. As such, this study proposes to explore what Counselling Psychologists think about male sexual dysfunction and their therapeutic approach to the phenomenon. The researcher hopes to interview ten participants and use qualitative analysis to contribute to the limited knowledge and research base. In addition, the project hopes to promote reflective and reflexive practices within the profession.

What is expected of participants?

To be able to participate in this research participants will need to be a counselling psychologist (qualified or in-training) and have worked with at least one client with male sexual dysfunction. Some examples of examples of male sexual dysfunction are erectile dysfunction and premature ejaculation.

Participants will be invited to participate in an audio-recorded interview lasting approximately 60 to 90 minutes. The interview will take place at the University of Roehampton or at an appropriate location convenient for the participant. The semi-structured interview will focus on the participant's thoughts, experiences and therapeutic practice with clients presenting with male sexual dysfunction.

What about confidentiality?

Before participating in the study participants will be required to sign a consent form indicating approval to the recording of the interview and participation in the research. In line with the British Psychological Society's guidelines for Ethical Principles for Conducting Research with Human Participants, the researcher guarantees complete anonymity and confidentiality of any collected information.

Breaches to confidentiality will only occur if the research participant indicates involvement in unlawful behaviour including breaches of national security, or if the research participant indicates a risk of harm to self or others. All collected data will be securely stored at all times and kept for a maximum of ten years for the purpose of publication.

Although participants will be asked to draw on their experiences of client work they are asked not to reveal any confidential or identifying details about their clients.

Concerns regarding anonymity or confidentiality can be raised with the researcher and discussed prior to engagement in the study.

All participation is voluntary. Should participants wish to withdraw from the study at any time, or retract their contribution, they are free to do so. Participants must state their unique identifier, found on the Consent Form, when withdrawing from the project.

How will findings be disseminated?

Participants may request a summary of the study's findings by explicit request from the researcher and by providing their contact details. Participants understand that findings of the research project may be published in journals and that anonymity and confidentiality will be upheld.

Will participants get paid or reimbursed for expenses?

Unfortunately, no costs related to the participation will be reimbursed.

Are there any risks to participating?

The issue of male sexual dysfunction and previous work with clients may be evoke upsetting or distressing thoughts or feelings. Participants are entitled to decline to answer any interview question and may take short breaks during the interview process if required. To ensure the safeguarding of participants' well-being, both participant and the researcher, reserve the right to terminate the interview at any point should the participant become excessively distressed during the interview.

Should participants experience unwanted distress as a result of participation they may refer to contact details for help-lines and therapeutic services which will be supplied in their debrief information sheet.

For further information or to raise a complaint

Should you any part of this research be a cause of complaint please contact the researcher's supervisors to address any grievances. Details given below:

Supervisor

Dr Jean O'Callaghan
Principal Lecturer
University of Roehampton
Whitelands College
London SW15 4JD
Email: J.OCallaghan@roehampton.ac.uk
Tel: +44 (0) 208 392 3624

Director of Studies

Dr Anastasios Gaitanidis
Senior Lecturer
University of Roehampton
Whitelands College
London SW15 4JD
Email: Anastasios.Gaitanidis@roehampton.ac.uk

Appendix 3 – Participant Consent Form



Participant Identifier: _____

PARTICIPANT CONSENT FORM

Counselling Psychologists' Constructions and Practices Related to Male Sexual Dysfunction

Brief Description of Research Project:

The aim of this research project is to explore how Counselling Psychologists construct and practice in relation to clients affected by male sexual dysfunction.

The research project aims to interview ten counselling psychologists (qualified or trainees) whom have worked therapeutically with at least one client affected by male sexual dysfunction.

Participants will take part in a single audio-recorded interview lasting approximately 60 to 90 minutes. Interviews will be transcribed and analysed using a critical qualitative approach.

It is hoped that the findings from the study will foster an increased reflexive position for Counselling Psychologists when working with clients affected by male sexual dysfunction.

Investigator Contact Details:

Lee Jones

Trainee Counselling Psychologist

Psychology Department

Roehampton University

Whitelands College

London SW15 4JD

Jonesl28@roehampton.ac.uk

Consent Statement:

- I agree to take part in this research, and am aware that I am free to withdraw at any point.
- I understand that the information I provide will be treated in confidence by the investigator unless there is an indication of risk or serious harm to myself or others, in which case relevant authorities will be notified.
- I understand that my identity will be protected in the publication of any findings.

Name: _____ Date: _____

Signature: _____

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:

Dr Anastasios Gaitanidis
University of Roehampton
Whitelands College
London SW15 4JD
Email:
Anastasios.Gaitanidis@roehampton.ac.uk
Tel: +44 (0)20 8392 4529

Head of Department Contact

Details:
Diane Bray
University of Roehampton
Whitelands College
London SW15 4JD
Email : D.Bray@roehampton.ac.uk
Tel: +44 (0)20 8392 3627



INTERVIEW SCHEDULE

1. Could you tell me about your experience of working with male sexual dysfunction?
2. What do you think about the presenting problem of male sexual dysfunction?
3. What do you think has informed your practice whilst working with male sexual dysfunction?
4. Is there anything else you would like to talk about or mention with regards to male sexual dysfunction?

Appendix 5 – Participant Debrief Sheet



Participant Identifier: _____

DEBRIEF INFORMATION SHEET

Counselling Psychologists' Constructions and Practices Related to Male Sexual Dysfunction: A Foucauldian Discourse Analysis

Thank you for taking part in the research project. Your participation is greatly appreciated. If you have any questions relating to the research or aspects you wish to discuss please speak with the researcher now.

How to contact the researcher in future

Researcher: Lee Jones, Trainee Counselling Psychologist

Address: Psychology Department
Roehampton University
Whitelands College
London SW15 4JD

Email: jonesl28@roehampton.ac.uk

Tel: XXXXXXXXXX

Please use the above contact details if you would like to:

- discuss any aspect of the research in future
- request a summary of the findings
- withdraw consent from the research

Please quote your participant identifier when corresponding with the researcher (found at the top of this information sheet and your consent form).

How to make a complaint

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:

Dr Anastasios Gaitanidis
University of Roehampton
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Head of Department Contact Details:

Diane Bray
University of Roehampton
Whitelands College
London SW15 4JD
Email : D.Bray@roehampton.ac.uk
Tel: +44 (0)20 8392 3627

SUPPORT

If your participation or any aspect associated with your participation in the research project raises feelings of distress or upset please contact your supervisor or supervisory team. In addition, please find below a list of possible options for further advice and support.

British Psychological Society (BPS)

Website: www.bps.org.uk
Tel: 0116254 9568

A national licensing body that provides contact details to a host of fully licensed psychologists working within a broad selection of therapeutic approaches.

British Association for Counselling and Psychotherapy (BACP)

Website: www.bacp.co.uk
Tel: 08740 443 5252

A national licensing body that provides contract details for a host of psychotherapists and counsellors.

Saneline

Website: www.sane.org.uk
Tel: 0845 767 8000

Provides a confidential help-line supplying information and emotional support for a range of mental health difficulties.

Samaritans

Website: www.samaritans.org

Tel: 08457 90 90 90

Offers a 24 hour support help-line service.

Additional information about free local treatment providers and voluntary support organisations will be available by contacting your general practitioner.